

EXPERIENCE IN EVERYDAY NURSING PRACTICE:

A Study of 'Experienced' Surgical Ward Sisters

by

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ABSTRACT

Experience in practice is frequently talked about in nursing but seldom examined with the rigour and depth it merits. The aim of this interpretative study is to explore the nature of everyday experience in nursing practice and its relationship to the development of nursing expertise.

The study took place in two acute care hospitals in a Scottish city. Participants were ten surgical ward sisters, considered by their nursing managers to be excellent, experienced clinical nurses. Field notes and interview transcripts were produced from two periods of participant observation and three interviews with each Sister, along with a group interview. A hermeneutic interpretation was undertaken with the text and the subsequent interpretations were validated with the Sisters and other nursing colleagues.

Everyday experience, as revealed through the systematic analysis of the interview transcripts and field notes, appeared more complex and fluid than the empirical literature generally suggests. Experience was found to be closely linked to the Sisters' moment-by-moment practices, which emerged as purposeful, complex, multifaceted and patient-centred. The Sisters' practices are aimed at making the ward work in order to help individual patients towards recovery. Underlying these practices, a process of noticing, understanding and acting could be discerned. Through this process, which stems from a stance of involvement and care, the Sisters are attuned to experience: their own, the experience of others around them, but most importantly perhaps, to the patients' experience. It is suggested that being attuned to experience is critical to developing expertise in practice. Concomitantly, expertise emerges as relational and context-specific.

Current discussions in nursing concerning practice, experience, knowledge and learning frequently distinguish as discrete entities, notions such as theory and practice, learning and experience, action and reflection. Proposals are then made to bring these entities together. It is argued that such notions are revealed to be inextricably intertwined in everyday nursing practice and experience. Thus, more subtle distinctions are advanced. A notion of 'knowing-in-practice', which is both theoretically and practically imbued, is proposed. Knowing-in-practice is temporal, located solidly in the present situation, but drawing from the past and acting towards future possibilities. It develops through being attuned to experience.

Finally, implications for clinical practice, basic education and staff development are discussed. It is suggested that hermeneutic phenomenology offers a fruitful way to study everyday experiences and practices while maintaining their contextual and experiential integrity.

DECLARATION

I DECLARE that this thesis has been composed by myself; and that the research which it reports is my own work.

Martha L.P. MacLeod

May, 1990

*To my mother
Laura Margaret Smith Peach
whose own wisdom and valued experience
merits greater recognition*

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The ten Sisters in the study shared themselves and their nursing practice with me most warmly and openly. I am privileged to have been able to work with them and to be able to tell about their practice and experience. Their interest and encouragement through the later phases of the research helped to sustain the momentum when it otherwise might have flagged. I could not have hoped to have worked with a more professional, caring group of excellent practitioners.

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CHAPTER 1

INTRODUCTION

The need for nursing expertise has never been greater in acute care hospitals both in North America and the United Kingdom. The "inexorable continuation of the trend towards shorter hospital stays" (Moore 1989) coupled with the ageing population, changes in patterns of illness, rapid advances in technology and the accompanying changes in medical practice have meant that patients in hospitals have ever more complex care requirements. To respond to such demands with "ingenuity and the development of innovative practices" (Auld 1988, 85), the development, support and retention of experienced nurses with clinical expertise is critical. This is perhaps more easily said than done, particularly when the nature of experience and the development of expertise in nursing practice is so little understood. It is complicated by the fact that learning has long been studied within educational contexts, but learning that is independent of efforts to educate has received scant attention, even in the context of adult learning (Thomas 1986). Such "natural" learning occurs in the midst of ongoing, everyday activities. It is common for us, working day-by-day, to experience a deepening of knowledge and an increase in our range of skills and abilities to manage an ever wider variety of situations. Indeed, we may extend our knowledge and skill without any direct attention to the learning that we do. We take it for granted.

This study is about this sort of taken-for-granted everyday experience. Specifically, the aim of the study is to explore the nature of everyday experience in nursing practice with a view to gaining an understanding of how that everyday experience contributes to the development of nursing expertise. The participants in this interpretative study are ten surgical ward sisters who are considered by their nursing managers to be "excellent, experienced" surgical nurses. Through a hermeneutic analysis of interview transcripts and field notes gathered from periods of participant observation, an interpretation is offered of the Sisters' everyday experience and practice.

This study stemmed from a personal interest as well as a need in the profession. As head of a school of continuing education in a large Canadian teaching hospital I was involved in the development of educational programmes to meet the need

for nurses prepared for advanced clinical practice in specialty areas. In the course of planning for curriculum and organizational changes, I was intrigued by the common-sense knowledge amongst the teachers and head nurses (ward sisters) about the amount of experience needed by nurses to manage certain patient care situations. Some curricular and organizational decisions were based on this common-sense knowledge. I began to realize how little understanding we have of the nature of everyday experience. Compared to experience which is a part of formal education endeavours, everyday experience in the course of working as a nurse has been little valued. It also has received scant attention in the nursing research literature.

Everyday experience merits in-depth examination for several reasons. First, is the dearth of formal knowledge about the substance of nursing practice, what Meleis (1987) calls "the business of nursing". The substance of nursing lies in those caring practices which help people "...in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that they would perform unaided if they had the necessary strength, will, or knowledge" (Henderson 1966). Such caring practices are often difficult to articulate because of their complexity and the reliance on the context for their meaning (Kitson 1987). An exploration of the knowledge and skills of experienced practitioners allows the practices to be revealed (McFarlane 1977, Benner 1984). As I will argue later, most studies focus on particular aspects of nursing practice; the full complexity of practice only comes to light in the ongoing context of everyday experience.

The second reason for an in depth consideration of everyday experience is its relationship to the development of clinical competence. Everyday experience in clinical nursing practice is considered to be essential to developing knowledge and skills, as nursing is a practice-based profession (NBS 1989, UKCC 1987). Experience in practice is necessary for learning, not only for students, but also for the ongoing development of expertise. A certain length of experience in a clinical area is often a pre-requisite to entry into a post-basic course or for consideration for a more senior nursing post. But despite the common-sense knowledge that experience accompanies the development of expertise in a field, the link between them is relatively unexplored.

Several studies have examined the learning which occurs in experience in clinical practice. Lathlean, Smith and Bradley's (1986) evaluation of a programme for newly registered nurses is not untypical. They delineated two different kinds of experience in clinical practice. Experience was described as:

... *experience per se* (i.e. that which happened merely as a result of working as a registered nurse regardless of the particular environment) and *experience with specific conditions* or features which facilitated the learning, some of which existed by design (e.g. working alongside a highly skilled ward sister on a number of pre-arranged shifts) and some by accident (e.g. caring for someone with a rare disease who happened to be admitted to the ward). (Lathlean, Smith and Bradley 1986, 59)

This distinction between "experience per se", and "experience with specific conditions" is an interesting one. The authors suggest that newly registered nurses learn more productively through specific kinds of experience. Indeed, educational structures and programmes are designed in order that nurses may have specific, and often guided clinical experience. In agreement with Lathlean, Smith and Bradley (1986), Robinson and Elkan (1989) suggest that the two traditional methods through which learning takes place, "experience" and "role modelling", have their limitations: they are likely to reinforce the status quo, irrespective of the quality of the care provided; they are restricted in their applicability to the present role and they rely on qualities in newly registered nurses which not all newly registered nurses have, such as their ability to identify where they need help. While this argument is well taken, it embodies a certain contradiction when extended, as it often is, to the education of experienced practitioners (cf. Working Party on Continuing Education 1981).

The contradiction centres on the fact that practitioners extend and deepen their skills and knowledge without educational interventions. It is acknowledged that staff nurses and ward sisters gain their knowledge and skills largely in everyday practice: "They learn mainly from personal experience and from observation...." (Working Party on Continuing Education 1981). While it is properly argued that educational programmes, particularly patient-centred ones (Henderson 1980, Dick 1983, Pembrey 1989) are critical in order to develop sufficient numbers of nursing practitioners with the advanced levels of skills needed to provide the required level of care, it cannot be denied that some nurses develop expertise in their day-

by-day practice, sometimes without the benefit of such formal education programmes. At the same time, it is recognized that some staff nurses and ward sisters advance the development of nursing knowledge through their ongoing practice. As Dick (1983) says about the excellent practising nurse: "She is scholarly in the sense that she knows what questions to ask to resolve problems in nursing care and to advance nursing practice." McFarlane (1977) reminds us of our impressions of the wisdom of experienced ward sisters, "If we could only catch their wisdom and write it down we would have a rich feast of concepts of nursing practice." I will be arguing in the following chapters that we should not discount ongoing, moment-by-moment experience because of its importance in the development of expertise.

Before moving on to an overview of the chapters, it may be useful to explain how I came to study "excellent, experienced" ward sisters. When I first came to Scotland, I sought to study "expert" nurses, as Benner (1984) had done. Early discussions at the University and with nurses in the clinical area indicated to me that the word "expert" was an unfamiliar one, particularly in the context of a bedside nurse. I was questioned countless times about why I wished to do the research in Scotland. Typical comments were: "The funding is so bad, all nurses can do is physical task care", "Where will you find experts? The good ones don't stay in nursing for long", "But American nursing is ten years ahead of us!" These comments intrigued me, as nurses from the U.K. generally have a reputation in Canadian hospitals for being good, thoughtful bedside nurses who keep the patient at the centre. When I met with the Directors of Nursing Services in the two hospitals in which I conducted the study, they agreed that the word "expert" was ambiguous, but they readily identified "excellent, experienced" surgical nurses, most of whom were ward sisters. Chapter 4 contains details of the process through which the Sisters were selected.

This difference in language is an inescapable part of this study. One of the complicating factors in any discussion of nursing practice and experience in the United Kingdom by a Canadian is the sharing of the English language. The weather provides a fine example of this. In Edinburgh, a day in which the temperature reached 23° Celsius was described on the radio as a "scorcher", whereas in Winnipeg it would need to be well over 30° Celsius before "scorcher" would be used. Although many of the terms and notions in nursing practice and experience are shared between Scotland and Canada (and the United States if we

consider much of the nursing literature), they have differences of meanings or nuances of meanings. Because the words are the same, we often assume their meanings are the same when they are not. I hope that in this study I have adequately captured the meanings in the Sisters' practices and experiences, and that the differences in culture and language have uncovered as much as they have hidden in this exploration of everyday experience.

The structure of the thesis is as follows. Chapter 2 begins with an exploration of how experience has been depicted in the learning and experience literature. This literature, drawn upon extensively in nursing education, proposes a number of ways of understanding experience and the learning which accompanies it. It is suggested that much of the literature treats experience as if it were non-problematic. The development of expertise is the basis of the second part of the chapter. It is suggested that the Dreyfus Model of Skill Acquisition (Dreyfus and Dreyfus 1986) provides a useful perspective on expertise because of its attention to the contextual nature of knowledge and the connection between experience and the development of expertise.

Chapter 3 details the various approaches which have been taken to the study of nursing practice. Particular attention is paid to studies of the ward sister. It is argued here that the approach used by Benner (1984, 1985) captures the complexity of nursing practice missing from other studies. It seems appropriate to adopt a similar approach in this study.

A brief discussion of hermeneutic phenomenology, which informs the approach to the study, opens Chapter 4. It provides a context for the discussion which follows of the particular steps that I took in each stage of the research.

In Chapters 5, 6, 7 and 8, themes which emerged from the analysis of the Sisters' accounts and my observations of their practice are discussed. In Chapter 5, the problematic nature of experience is addressed. Rather than being static and spatial, everyday experience was found to be elusive, complex and continually changing; in continuous interplay with the Sisters' ongoing practices. Chapter 6 describes what I understand the Sisters to be doing as they practice. I have suggested that they help individual patients towards recovery, and in order to do this, they make the ward work. Their practice was seen to be patient-centred,

complex, goal-directed and multifaceted. In Chapter 7, the inextricably intertwined process through which the Sisters practise nursing: noticing, understanding and acting, is described. I suggest in this chapter that the quality of this process contributes to their expertise in nursing. In Chapter 8, I argue that this process of practising is also the process of developing expertise. The various ways in which the Sisters learn in everyday practice are explored.

In the final chapter, the themes are extended to a discussion of being attuned to experience. I shall argue, that it is through this process that the Sisters practise and develop expertise. I suggest that the "knowing" which develops through being attuned to experience is more complex than is conventionally depicted in the theory-practice discussions in nursing. Likewise it is argued, that the customary separations of action/reflection and learning/experience are less useful for understanding the development of expertise in everyday experience than is the more subtle process of being attuned to experience. It is suggested that by looking anew at everyday experience in nursing practice the value of that experience and practice and their contribution to the development of expertise will be revealed.

CHAPTER 2

EXPERIENCE AND THE DEVELOPMENT OF EXPERTISE

INTRODUCTION

Experience, as a word and a phenomenon, is notoriously slippery. Although it is commonly understood and taken-for-granted in everyday conversation, it becomes elusive upon direct examination. The everyday usage of the word experience, gives a hint of its complex nature. The Shorter Oxford Dictionary describes experience variously as the observation of facts or events, being consciously the subject of a state or condition, the state of having been in everyday life, and as well, the effects of having been so engaged. To further complicate matters, to experience is to have experience. Clearly then, even in colloquial use, experience has various shades of meaning. Generally however, experience refers to something which has gone before as well as to action ongoing in the present.

In its scientific and philosophical sense, experience is also elusive. In various philosophical traditions, for example, experience has been construed as an objective phenomenon, a subjective phenomenon and a phenomenon concerned with being-in-the-world. No greater consistency is evident in the use of the term in empirical studies. This is understandable perhaps, because the nature of experience is so closely tied up with what it means to be a person, living and being in the world. Therefore getting either a clear or unitary picture of experience may not be possible.

The debate about experience has been substantial and wide ranging. While it would be possible to recap the various philosophical positions on experience, and review the trends in empirical studies which consider various aspects of experience, the magnitude of the task would be such as to extend well beyond the bounds of the present study, while diverting discussion away from the more pertinent question of the nature of everyday experience for experienced nurses. For the purposes of the present study, a more fruitful approach is to examine two different but related bodies of literature which afford, each in their own way, a view into the 'black box' that is everyday experience and the contribution

experience makes to the development of expertise in nursing practice. The first concerns learning from experience and what is often called experiential learning. A group of studies, emanating primarily from the adult education literature, discuss ways in which people gain knowledge from experience in specific situations. The second concerns knowledge and its relationship to the development of expertise in nursing. These studies provide various perspectives on the outcome or effect of experience, and how knowledge, experience and expertise have been seen to interconnect. Thus, the following discussion will explore several perspectives on the nature of experience and the development of knowledge and nursing expertise.

EXPERIENCE AND LEARNING

In the literature on learning from experience, learning receives the bulk of attention and experience is conceived for the most part, as the ground or source for learning. This is perhaps to be expected as most authors of the studies are educators, concerned with understanding learning so they may better facilitate it. Concomitantly, most of the studies concern the experiences of adult learners in "deliberate learning" (Tough 1979), usually classroom, situations. A few studies look at learning experiences outwith the classroom and fewer still concern "natural learning", learning which happens incidentally in the midst of other activities. These last studies have most direct relevance to this current study of everyday experience in nursing practice. However, because they draw on models which have been developed from deliberate learning situations, it is important to begin the review with an examination of how experience is depicted in studies of deliberate learning.

Before turning to these studies, it may be useful to briefly consider how experience is viewed in definitions of experiential learning. Experiential learning, a designation which is gaining currency in the adult education and nursing education literature, describes various forms in which learning and experience are linked. Sometimes, it is used to describe the form of education as well as the learning which occurs. In a survey of educators involved in experiential learning (Henry 1989), the minority view was that all learning was experiential. More frequently, experiential learning was considered to be a sequence of stages of which experience was but one. The educators taking this view felt that, "... experience alone [is] not enough, to count as experiential learning: the

'experienter' had to consciously realize the *value* of that experience" (Henry 1989, 28). This view, of the need to bring experience to conscious awareness in order for learning to occur, is a recurring one. It is based on an underlying assumption that experience and learning are separate entities. This position, I will argue, reflects a particular view of experience which merits re-examination.

Deliberate Learning Experiences

"Deliberate learning" experiences (Tough 1979) are experiences planned with learning in mind. They are usually part of educational programmes, either inside the classroom or in the workplace, but also may be part of self-directed learning projects which can occur in any part of a person's life (Tough 1979). In any case, the goal of the situation is learning and "learners" are aware that they are learning. Models of experiential learning have been developed, for the most part, from deliberate learning situations, particularly those in which the goal of learning is more than merely the acquisition of information.

Experiential Learning Models

In the discussion which follows, seven models are singled out for attention: those of Lewin (1952), Revans (1980), Kolb (1984), Jarvis (1987a, 1987b), Boud, Keogh and Walker (1985), Mezirow (1981) and Argyris and Schön (1974). Common to all is the centrality of concrete experience as the source and testing ground for learning. All are cyclical in nature, with some form of feedback loop in which learning from one experience influences the next. As we shall presently see, although the models are grounded in experience, the theorists do not excavate that ground. The focus of the models is on learning, particularly learning which restructures perceptions of situations and oneself (Boydell 1976).

Action Learning

One of the first experiential learning models, Lewin's model of action research and laboratory training (Lewin 1952), is described as a social learning and problem-solving process. The model, developed from work with groups, emphasizes the importance of concrete experience to validate and test abstract concepts. Experience is considered to provide a robust source for concepts and a context for testing them but it is not explored in any detail. Lewin's focus is on the social field

and on the interplay between the "subjective", perception and the "objective", action (Lewin 1952, 199). The four stages of learning which Lewin identified: concrete experience, observations and reflections, formation of abstract concepts and generalizations, and testing implications of concepts in new situations, have continued to be the major stages of experiential learning models which have followed.

Revans (1980), in the context of management education programmes, has developed a theory of "Action Learning", in which the learner (manager) learns to solve problems in real-life situations. Like Lewin, Revans suggests that learning is an adaptive process of behavioural change involving a circular learning process. He links action learning to the scientific method. Revans' concentration on ongoing problem solving leads him to argue that research, learning and action are interconnected in management education.

Kolb's Experiential Learning Model

Predominant amongst the current experiential learning models is Kolb's (1984) model. As it is so influential, it will be explored in some detail. This model was developed from Kolb's work in management development programmes and stems from the traditions of Dewey, Piaget and Lewin in cognitive and social psychology. Learning is viewed as a process of human development, "the process whereby knowledge is created through the transformation of experience" (Kolb 1984, 38). The model centres on the interconnection of knowledge and learning. Knowledge is not considered to be an independent entity to be acquired or transmitted: it is "a transformation process being continuously created and re-created" (Kolb 1984, 38). The transformation process occurs in the interplay between expectation and experience.

In Kolb's view, experience is where learning begins and ends. Experience is concrete: something that happens to a person and in which a person is involved. Citing Dewey (1938), Kolb considers experience to be a transactional relationship between the person and the environment, between the internal or subjective and the external or objective. But according to Kolb, experience in itself is not enough. It must be grasped and transformed. The grasping is done in one of two ways: comprehension and apprehension. Comprehension refers to symbolic representation and conceptual interpretation. Apprehension refers to the

sensations or feelings of immediate experience. Once experience has been grasped it is transformed, again through two basic yet independent processes: intention and extension. Intention consists of internal reflection on what is apprehended or comprehended and extension consists of manipulating the external world as it is comprehended or apprehended. This process is most frequently depicted by a four stage cycle (Kolb 1984, 21, Kolb and Lewis 1986).

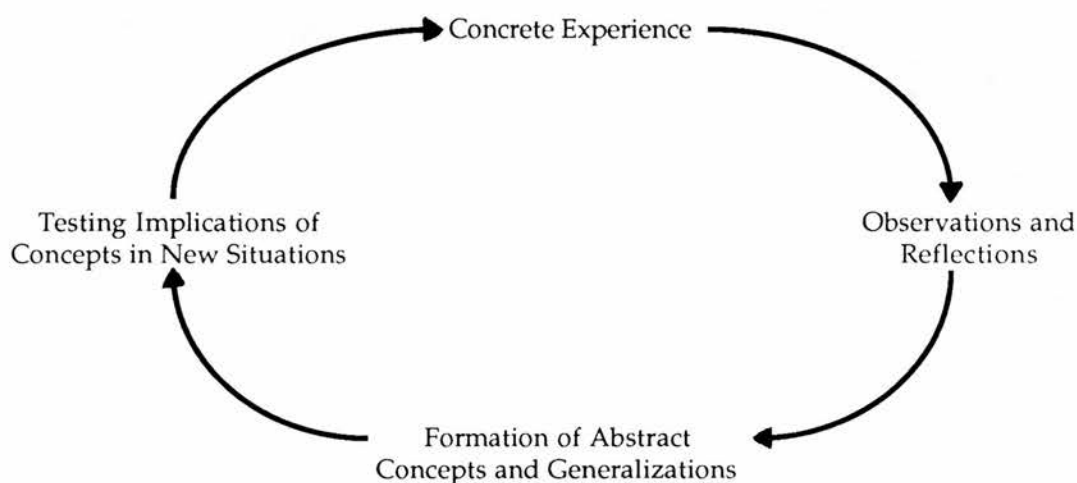


Figure 1. Kolb's Experiential Learning Model

In the cycle, immediate, concrete experience is the basis for observation and reflection (the grasping of experience through apprehension and comprehension). In turn, these observations are "assimilated into an idea or theory from which new implications for action can be deduced" (Kolb and Lewis 1986). This is intention, the creation of concepts which integrate the observations into logically sound theories. Next, these theories are used to make decisions and to solve problems: through extension new experiences are created. Thus, not only are learning and experience separate and then integrated, but also action and reflection are considered to be disparate entities.

While Kolb emphasizes the importance of experience, he spends very little time examining what he means by it. The depiction of experience as a series of discrete entities, happening in real life is consistent with the source of the model, meaningful experiences discussed in management classes, and with the conceptual roots of the model. This very specific conception of experience is often overlooked when the model is extrapolated to other situations.

In Kolb's discussion of facilitating experiential learning, the separation of learning and experience extends to the place where each may occur. "Immediate, concrete experiences that occur outside the classroom serve to arouse observation, prompt reflection and spur action" (Kolb and Lewis 1986). Even though Kolb describes learning as an adaptive process in which individuals adapt to their social and physical environments, he does not develop the link with everyday experience to any great extent. His depiction of the experiential learning process remains somewhat removed from the everyday, moment-by-moment flow of living.

Learning in the Social Context

Citing the confines on Kolb's model created by the narrow source of experiences, Jarvis critiques the model for its limited recognition of the social realm, its simplicity, particularly in respect to the complexity of experience and learning in natural situations and the fact that it overlooks the issue of meaning in learning. Jarvis goes on to create a new, complex model from data provided by 200 educators of adults in workshops about adult learning and its relation to teaching. Participants were asked to think about any learning experience they had had, to record what started the process, how they learned from the experience and what completed the process.

Perhaps because of this source of data, Jarvis explores experience to a greater extent than do other experiential learning theorists. Although Jarvis recognizes that "experience in the real world is a very complex phenomenon" (Jarvis 1987a, 26), and identifies sixteen different kinds of experience, the complexity is not evident in his descriptions. He consistently describes experience as an entity "which is itself socially constructed and received through a variety of senses" (Jarvis 1987a, 84). As an entity, experience contains sense data which can be used in learning (Jarvis 1987a, 149). Separated from experience is reflection, which occurs retrospectively upon experience.

Jarvis' separation of experience and reflection is consistent with his distinction between an experience and a learning experience. He follows on from Berger and Luckmann (1967) in distinguishing between a situation and experience. He holds that "... it is the subjective definition of the situation which creates the experience and potentially leads to learning" (Jarvis 1987a, 70). The connection between the individual and their situations is depicted as an interplay between the subjective

and objective through the imposition by the individual of subjective, socially constructed meanings upon objective, socially defined situations.

This separation of subject and object is carried through in his depiction of learning which, he contends, results from a disjunction between the individuals' biography "and the socio-cultural milieu in which the experience occurs" (Jarvis 1987a, 79). As the individual confers meaning upon situations some experiences may be meaningless to the participants, preventing learning from happening (Jarvis 1987a, 76, Jarvis 1987b). He suggests that there may be nine different routes which learning may take from an experience and organizes them into a hierarchy, with the first three being non-learning responses, the next three being non-reflective learning and the last three, reflective learning. Although he recognizes the necessity of the "lower" types of learning, Jarvis, like the other experiential learning theorists, places a higher value on reflective learning for its contribution to personal growth and development.

While Jarvis extends Kolb's work to include a broader range of situations, and delineates a variety of ways in which learning can emerge from experience, he, like Kolb, treats experience as a non-problematic, static entity.

Models of Reflection

Reflection is at the centre of the other three prominent models of experiential learning: Boud, Keogh and Walker (1985), Argyris and Schön (1974) and Mezirow (1981, 1989). For Boud et al., experience is the starting point and the object of reflection; for Argyris and Schön, experience is the source and testing ground of theories of action which are formulated during periods of reflection; Mezirow (1981, 1989) considers experience to be the ground for transformative learning.

Boud, Keogh and Walker define experience as a static, though perhaps complex, entity. Even though an initial experience may be "quite complex and is constituted of a number of particular experiences within it" (Boud et al. 1985, 19), it is essentially a source of data. The data come from the experience: "the total response of a person to a situation or event: what he or she thinks, feels, does and concludes at the time and immediately thereafter" (Boud et al. 1985, 18). Unlike Jarvis, they do not discern between learning experiences and non-learning experiences. However, they are concerned with those learning experiences in

deliberate learning endeavours which can be described and recalled by the participants as discrete entities. Thus, in Boud, Keogh and Walker's model, the dichotomy between experience and reflection serves to emphasize reflection because they consider this processing of experience to be the key to learning.

Mezirow (1981, 1989) situates his theory of transformative learning in the broader context of Habermas' theory of communicative action. He suggests that there are two learning domains (instrumental and dialogic), and an emancipatory learning process in which critical reflection plays an important part. Through critical reflection on the presuppositions of uncritically assimilated meaning schemes and perspectives emanating from experience, individuals, groups and collectives can engage in a process of perspective transformation. Again, experience is relatively unexamined in Mezirow's formulation: he concentrates on processes and levels of reflection which enable what he calls, "perspective transformation".

Unlike the other experiential learning models, Argyris and Schön's (1974) Theory of Action Perspective does not talk directly of experience. Instead they describe a fairly mechanistic, behavioural world in which actors design their behaviour for interpersonal action and hold theories for doing so. They suggest that theories operate at two levels: espoused theories which people use to explain or justify behaviour, and theories-in-use which are implicit in people's patterns of spontaneous behaviour with others. Argyris and Schön describe two models of theories-in-use: Model I, in which existing patterns are maintained, and Model II, in which the values and assumptions underlying them are explored and changed towards a more open, effective behavioural world. They contend that most people's theories-in-use are of the Model I variety although their espoused theories may differ. According to Argyris and Schön, learning occurs in a single-loop or double-loop pattern. Single-loop learning retains the status quo; the more reflective double-loop learning involves questioning underlying assumptions and values. Not surprisingly, Argyris and Schön argue for an increase of Model II action and double-loop learning. Again in this theory, there is separation of the person (actor) and the (behavioural) world. Experience, when it is touched on, is described in terms of a subjective phenomenon.

Overall, the picture of experience and learning painted by the experiential learning models is somewhat stark and compartmentalized. Experience, learning, reflection and action are described as being distinct and are connected in specific, sequential and circular ways. Although experience forms the ground for all of the models, with the single exception of Jarvis' model, it remains unexamined. And even in that model, experience is relegated to a composite of sense data. Notable in all of the models is the independence of the individual actor and the distinction of experience as a purely subjective or purely objective phenomenon.

The Experience of Learners

There is a growing body of research in adult education which examines the experience of participants in educational programmes. Of particular interest are those studies (cf. Taylor 1986, Chené 1985, Griffin 1987), which begin in the deliberate learning situation, but explore experiences which extend beyond the specific learning situation. Because much of the research on student learning experiences (cf. Marton, Hounsell and Entwistle 1984) remains in the sphere of intellectual development: namely writing essays, learning from reading, or learning from lectures, it will not be reviewed here.

In her study of post graduate students' experience in a course which promoted their own self-directed learning, Taylor (1986, 1987) identified common patterns in the learners' weekly reports. She found that learners proceeded through a common chronological sequence of phases and transitions (Taylor 1986) which was not unlike Kolb's (1984) learning model and had features resembling Mezirow's (1981) perspective transformation. Chené's (1985) study of the narratives produced by learners in an adult learning course likewise revealed a sequential, staged transformation in experience during the course which extended to the learners' global life experience. Both Taylor's and Chené's studies illustrated that when people considered their learning in the programme, they intermixed their experiences within and outwith the programme. Additionally, Taylor's (1987) study revealed some of the overlooked dimensions of learning experiences: the emotional nature of learning, the role of intuition, the relational quality of learning and the political dimension of learning.

From the learning experiences of students in her adult learning courses, Griffin (1987) developed the notion of basic learning processes, "inner happenings or

experiences the learner has when engaged in learning". The characteristics of learning processes reveal something about Griffin's view of the active and changing nature of learning experiences: they are denoted by verbs; the action is within the learner; the process happens over time; only the learner knows what he is experiencing. Griffin has identified six categories of processes which she describes as clusters of 'capabilities': rational mind, metaphoric mind, relational, emotional, physical and spiritual. Denis' 18 processes of intuitive learning are examples of the metaphorical mind (Denis and Richter 1987). A strength of Griffin's approach is her focus on a range of experience related to learning; the drawback is that with her view of experience as being wholly inside the learner, she maintains the subjective view of the person within an objective world.

Diekelmann (1988, 1989) presents a different perspective on experience in deliberate learning settings. Using the perspective of hermeneutic phenomenology, Diekelmann describes the lived experiences of students in various levels and types of nursing programmes. The view of experience which emerges in her study is relational, the experience of students in the context of educational programmes. Themes such as "Learning as Evaluation" which emerge for all students and constitutive patterns such as "Being in Practice - Returning to School", for registered nurses, describe the meanings for the students of the experience of learning in nursing programmes. Experience in this study is not solely in the learner, nor is the world presented solely as an objective reality. The experience of the students is intersubjective and contextual.

These few studies paint a more complex picture of experience than do the experiential learning models; the boundaries between experience and learning are much less clear-cut. However, with the exception of Diekelmann's study, learning continues to be the primary focus of the research, with experience remaining in the background as a source and a backdrop. This is understandable as the subjects of the research are intentional learners in educational programmes.

A very different picture of learning and experience is painted by the various studies of educational experience in workplace settings. Studies such as those by Atkinson (1981), Melia (1987), Moore (1986) and those compiled by Geer (1972), illuminate the organizational and social processes which influence the experiences of learners such as medical students, nursing students, barbers and work interns. Clearly illuminated are the situational learning which is required of

the learners, and in addition, the activities and constraints in the work milieu. Although the starting point in these studies is the experience of the learners, the analysis quickly moves away into the underlying social processes and dimensions of the learning situations. The experiencing person and the nature of experience moves to the background so that the social environment comes firmly into view.

Learning in Everyday Experience

Incidental or natural learning, learning which occurs in the midst of other, ongoing activities, has had a relatively short history of direct research attention. These studies focus more directly on the nature of experience, and characteristically, they present a dynamic view of experience.

Building from an earlier study (Burgoyne and Stuart 1976) which found that the greater part of learning of managerial skills comes from "natural" experiential sources, Burgoyne and Hodgson (1983) gathered 37 episodes of managerial work from eight managers in which the managers "thought aloud" while doing their work and were interviewed about the episodes afterwards. In a not unrelated study, Davies and Easterby-Smith (1984) interviewed 60 managers about their development as a manager. While the findings of the two studies were complimentary, their differences could be linked to the different time-frames with which they were concerned. The distinction made by the managers (Davies and Easterby-Smith 1984) between development and learning highlights the differences. For the managers, learning concerned short term gains - what the manager picked up gradually over time; development referred to acquiring greater competence over a longer period of time and was linked to promotion.

Concentrating on what the manager picks up in moment-by-moment work, Burgoyne and Hodgson (1983) found three levels of learning. First level learning concerned taking in some factual information or data which had an immediate relevance, but did not have a long term effect. During second level learning, the manager learned something in one situation which might be an aspect in another situation. Burgoyne and Hodgson found second level learning to comprise the most usual form of learning and identified five processes by which it occurred. Notable amongst them was the gradual and tacit change in orientation or attitude which occurred on the basis of cumulative experience. The third level of learning, in which the managers learned about their overall conceptions of the world was

found to be "comparatively rare". It is on their characterization of the gradual and cumulative nature of experience and the resultant change in outlook that their results diverge most from Kolb's (1984) and Argyris and Schön's (1974) experiential learning models. Although Burgoyne and Hodgson do not themselves make this connection, this divergence could be related to the static notion of experience conceptualized in the models as compared to the moment-by-moment experience of a normal workflow.

From retrospective interviews, Davies and Easterby-Smith (1984) found that development primarily came from being in new situations, where the managers had responsibility and thus had to take action. Success led to increased confidence and the willingness to develop further. This study highlights the influence of the organization on the individual's experience.

Rossing and Russell (1986, 1987) also studied natural learning experiences. Forty individuals involved in community problem-solving groups were asked to recall experiences which may have contributed to their current beliefs about effective functioning of community groups. Interestingly, the individuals had difficulty recalling specific events and making discrete connections between events and the learning derived from them. Situational factors were an important part of the learning instances: most happened in a person's early experiences with the group and few were recent or current. Like Burgoyne and Hodgson (1983), many beliefs were traced to a gradual accumulation of experiences rather than to specific events. Rossing and Russell (1987) contend that the reflective observation stage of Kolb's (1984) model does not seem to be necessary for learning to occur. Although they note the dwindling number of surprising or confounding experiences as group members become more accomplished, Rossing and Russell do not explore this further.

The Interplay of Past and Present

Quite a different perspective on experience and learning from experience is afforded by two qualitative studies (Hasselkus and Ray 1988, Gray-Snelgrove 1982), which consider both past and ongoing experience. Both studies concern caregiving: Hasselkus and Ray, with caregivers of the frail elderly in the community; Gray-Snelgrove, with adult children caring for parents dying of cancer. The view of experience which emerges in both of the studies is of a

complex phenomenon which is tied up with the meaning of ongoing activities. Although both studies reveal learning to be embedded in the ongoing situation and happening continuously, they diverge sharply in their descriptions of learning.

From their sixty ethnographic interviews with fifteen family caregivers, Hasselkus and Ray (1988) identified five themes of meaning in family caregiving (sense of self, sense of managing, sense of future, sense of change in customary role/relationship) which were linked to six patterns of informal learning (coming up with reasons, "they" know best, sharing what "works", critique and modification, teaching the professional how, figuring it out together). Hasselkus and Ray contend that these patterns of learning fit with Schön's (1983) description of professional knowing, "reflection-in-action". Thus, they suggest, as the caregivers cared for their family members, they were learning informally: the caregivers carried out "a reflective conversation with the situation as they named the things they would attend to and framed the context in which they would attend to them" (Hasselkus and Ray 1988).

Addressing the issue of time in experience and building herself into the research process, Gray-Snelgrove (1982) takes a unique approach to the issue of experience and learning. To study ongoing experiencing as well as the meaning in past experience, she engaged in a joint exploration with nine individuals, having four conversations with each. As she too had cared for a dying parent, her experiences were shared in the conversations. A hermeneutic analysis revealed the structure and dynamic of meanings of caregiving and sharing experiences, seen in the context of time. As well as identifying recurrent features of the caregiving event as they "penetrated through time", Gray-Snelgrove discusses the learning which emerged through shared reflection on experience. Of particular interest are her conclusions about how talking helps people to grasp their pre-reflective knowing. Experience in this study was shown to be an interplay between past and present, and ever changing in the present. Rather than a subjective phenomenon, experience was shown to be intersubjective, and linked to meaning which arose between people in specific situations.

In summary, even in a field devoted to the consideration of experience and the learning which accompanies it, the nature of experience is usually taken-for-granted or considered simplistically. Even though a few qualitative studies have focused more directly on experience, most have looked through the experience to the learning and have not addressed the potentially problematic nature of experience. Having said that, there are a small number of studies which do begin to examine the nature of experience and the connection with learning. Notably, these studies consider the relational nature of experience in the context of time and place, and consistently with Selman (1988), recognize the character of learning to be social and relational, and more than just an internal process.

It is also somewhat surprising, given the claim that experiential learning involves the whole person, that the body is almost completely overlooked by the experiential learning theorists and only minimally addressed by researchers studying learning experiences. Although Griffin (1987) and Denis and Richter (1987) address intuitive experience, and Griffin (1987), Gray-Snelgrove (1982) and Jarvis (1987a) allude to the body, in general, references to bodily experience and the development of bodily knowing are noticeable by their absence. Just as the body is separated from the mind in most of the studies, other notions are unduly separated. Many of these studies, particularly those underpinning the experiential learning models, separate learning/reflection, learning/experience, action/reflection. It is notable that these demarcations are not made as sharply in the studies concerning learning in the midst of everyday experience.

Concentrating on the mechanisms or processes of learning, these studies of learning and experience have not always identified specific outcomes of learning. However, when the overall goals of learning are mentioned, autonomy is frequently among them (Merriam 1987), along with greater understanding, personal growth and knowledge of one sort or another. It is to knowledge and the development of expertise that we now turn.

DEVELOPING EXPERTISE

In our common understanding, an expert is someone whose special knowledge or skill causes her to be an authority in a particular field or area. Likewise, expertise consists of expert knowledge or opinion. Although it is still unclear just how expertise develops, the close link between experience and becoming expert is

reflected in the words' etymological connection with "experiment". For inherent in both experience and expertise is the active testing, deployment and development of knowledge and skill.

At the centre of much of the current research on expertise is the concern about how people develop and use knowledge and skill. Most studies aim to discover how people think and make decisions in simulated or real conditions. The researchers' underlying view of knowledge, skill, and practice greatly influence how the studies depict expertise and its development. Thus, if we are to examine everyday experience in nursing practice and its contribution to the development of nursing expertise, it is important to consider the nature of knowledge and skill in professional practice.

Knowledge in Everyday Experience

Questions about the nature of knowledge in human experience have been the subject of continuous philosophical debate. It is beyond the scope of this study to review this complex and wide-ranging discussion. Rather, in this discussion I intend to distinguish conceptions of knowledge which underly current research on expertise in nursing practice and explore some of the issues which surround the connection between knowledge and practice.

Within the discussion about the nature of knowledge, a number of distinctions have arisen: distinctions between common-sense knowledge and specialized knowledge, generalized and particular knowledge, and theoretical and practical knowledge. This last distinction, between theoretical and practical knowledge, or knowing-that and knowing-how (Ryle 1949), is a useful way of considering theory and its connection to practice. Freidson (1986) provides a helpful elaboration of formal knowledge in professional action. He contends that formal knowledge is higher knowledge which remains separated from "both common, everyday knowledge and nonformal specialized knowledge" (Freidson 1986, 3). It is formalized into theories and other abstractions which are designed to provide systematic, reasoned explanation and to justify the facts and activities believed to constitute the world. Usually the subject of research and teaching, formal knowledge is characterized by rationalization: the pervasive use of reason and rational action. According to Freidson, experts are commonly considered to be the "carriers" of formal knowledge. This view is also held in nursing (cf. Christman

1985). The nursing literature is replete with distinctions of formal knowledge which is to be applied to practice in order to improve the care of patients.

In a profession, the way in which knowledge is conceptualized, described and transmitted illustrates which types of knowledge have most value and what it means to know (Carper 1978). In common with other professions (Freidson 1986, Clark 1989), what counts as nursing knowledge, with very few exceptions, is theoretical or formal knowledge (Beckstrand 1978, Carper 1978, Meleis 1985, Visintainer 1986). Non-formal ways of knowing are frequently overlooked or diminished in importance in the push to establish nursing's scientific footing. A good illustration of this lies in Carper's (1978) discussion of ways of knowing in nursing.

Through her analysis of the conceptual and syntactical structure of nursing knowledge, Carper proposes four patterns of knowing: empirics - the science of nursing; esthetics - the art of nursing; personal knowledge, and ethics - moral knowledge (Carper 1978). She contends that the greatest emphasis in nursing is on the science of nursing; the others constitute the 'art' of nursing. However, as she describes them, esthetics and ethics become various forms of theoretical knowledge: they can be abstracted, objectively described and shared. Personal knowledge is described narrowly; Carper contends that it cannot be shared because it is highly personal, subjective and idiosyncratic. Although Carper makes a case for broadening the consideration of what constitutes "valid and reliable" knowledge in nursing, she maintains a dichotomy between objective and subjective knowledge and reinforces the superior value of formal knowledge.

Following Heidegger (1962), Polanyi ([1958]1962), Kuhn (1970) and Dreyfus (1980), Benner (1983, 1984, Benner and Wrubel 1982) argues for making a distinction between theoretical knowledge and practical knowledge which does not follow these objective/subjective lines. She proposes a distinction between knowing which is embedded within a particular situation and knowing which is formal and abstract. Her view of practical knowledge and the connection between theory and practice will be discussed shortly. But, for the present, it is useful to note that for Benner, theoretical knowledge is abstract:

A formal statement of the necessary and sufficient conditions for the occurrence of real situations. Theoretical knowledge is "knowing that" and

includes formal statements about interactional and causal relationships between events. (Benner 1984, 298)

This definition is not unlike Meleis' description of nursing theory which shows the influence of, amongst others, Dickoff and James (1975). To Meleis, nursing theory is:

... an articulated and communicated conceptualization of invented or discovered reality pertaining to nursing for the purpose of describing, explaining, predicting, or prescribing nursing care. (Meleis 1985, 96)

Both definitions illustrate the fact that theoretical knowledge is abstract, definite, specifically related and readily communicated. It ranges from systematic knowledge that names and categorizes, to knowledge which tells what activities are necessary to reach a nursing goal. Even though it is commonly held that "theory begins and ends in practice" (Dickoff and James 1975, McFarlane 1977), the nature of the connection between theoretical knowledge and practice remains an open question. It is to this connection that we now turn.

The Theory-Practice Connection

It has been variously suggested that theoretical knowledge provides the "basis" of nursing practice (cf. Rogers 1970), that theory "guides" the nurse in action (cf. Jacox 1974) or that the nurse "applies" theory in practice (cf. Johnson 1968). Despite these contentions, empirical evidence about how nurses actually use or apply theoretical knowledge in their ongoing, everyday practice is scarce in the nursing literature. Indeed, there is evidence from research in other fields about how practitioners use knowledge (cf. Clark 1989, Eraut 1985) that the notion of the "application" of theoretical knowledge may be a mistaken one. This is not to say that theoretical knowledge is unimportant, nor to underestimate its positive influence on practice. Indeed, the introduction of the Nursing Process is a case in point (UK. DHSS 1986). It also cannot be forgotten that the formal knowledge which underpins organizational and documentary practices has a considerable influence on nursing practice, much of it positive. (cf. Campbell 1984, Gordon 1986). Notwithstanding the influence of formal knowledge on the organization, and thus on practitioners, the process through which individual practitioners

incorporate formal knowledge into their ongoing practices is not clearly understood (Freidson 1986). It merits closer scrutiny.

One view of the knowledge-practice connection is that nurses (and other practitioners) practise from a theory, or set of theories. This may be viewed in at least two ways. First: the nurse practises from broad, normative knowledge, for instance a model, view or perspective of nursing (cf. Field 1980, Field 1983, Kitson 1986). For example, Adam (1987) contends that this "theoretical perspective", which can be likened to a precursor to theory, determines the nurse's focus of attention and comes from a conceptual model or from outside nursing. Kitson (1986) has linked the presence of such a perspective on the part of ward sisters to the quality of care provided in the ward. Others (cf. Field 1980) emphasize that formal knowledge forms only a part of the nurse's "horizon" (Gadamer 1975) with which the nurse understands and interprets specific situations, and determines the goals for care.

In the not dissimilar fields of community work and social work, Clark underlines this position. He found that rather than working from a model for practice, practitioners were guided by "a set of action beliefs and dispositions which draws variously on the whole spectrum of the individual's knowledge, values, biography and experience" (Clark 1989, 224). Theoretical knowledge was only a minor part of this set. If the formal knowledge, or theoretical perspective accounts for only a part of how a nurse practices, then the link between theoretical knowledge and practice remains difficult to discern. Considering the connection between practice and a more specific notion of theory may be more productive.

A much narrower notion of theory underpins the second view of the relationship in which theory guides practice. One manifestation is situation producing theory (Dickoff and James 1975), which prescribes nursing practice from knowledge arising from predictive, causal, correlational and descriptive theories. In practice, the nurses would work from the prescriptive, normative theory, applying it as a template on their practice. Any mismatch between practice and theory would constitute a testing of the theory and thus the theory can be revised and new formal knowledge created. Although knowledge would not stand completely apart from action and would be generated from action, the knowledge thus developed would be a refinement of formal knowledge. Grypdonck (1980, 1987) has demonstrated the use of situation producing theory in implementing

the nursing process and notes how it helps the nurses to improve their care by strengthening the cognitive aspects of it. The theory of nursing process has been refined, for instance, through a reassessment of the need for written communication (Grypdonck 1987).

A less restrictive notion of the connection between theory and practice is provided by Benner (1984, Benner and Wrubel 1989). She suggests that theory is useful for pointing to an area of practice, and for guiding the novice.

Theory is crucial to forming the right questions to ask in a clinical situation; theory tells the practitioner where to look for problems and how to anticipate care needs. (Benner 1984, 178)

Benner's view is that although theory may be useful to practitioners, it is always secondary to practice (Benner and Wrubel 1989), and that it is derived from practice. Nevertheless, the notion of theory guiding practice is problematic in an occupation such as nursing where there are more uncharted areas of practice than areas where formal knowledge has been sufficiently developed to act as a guide. Nurses frequently encounter new situations in practice without the benefit of specific theory. Benner (1984) recognizes that there are many situations which may be "beyond" theory, and reiterates that there is more to any situation than a theory predicts. She further suggests that nurses use theory differently as they develop expertise. This point will shortly be more fully explored.

Freidson, in discussing the institutionalization of formal knowledge, adds an important dimension to this discussion. He suggests that the formal knowledge of a profession advanced by academics and researchers is "used selectively and transformed in the course of its use" by administrators and practitioners (Freidson, 1986, 217). In every workday situation, formal knowledge is

... employed inconsistently and informally. In each case a different transformation of formal knowledge into "working knowledge" (Kennedy 1983) takes place. (Freidson 1986, 227)

Working knowledge is considered by Kennedy (1983) to be an organized body of knowledge which is used spontaneously and routinely in the context of work.

Schön (1983, 1987) challenges what he calls the prevailing view of professional action, "technical rationality" and offers an alternative way of linking theory and practice. I would argue, however, that Schön's underlying view of the world is essentially the same as the prevailing view. Because some of his notions are particularly useful, it is important to consider his work here. As mentioned earlier, Argyris and Schön (1974) distinguish two levels at which theories of interpersonal behaviour operate: espoused theories which people use to explain or justify their behaviour, and theories-in-use, which are implicit in patterns of spontaneous behaviour with others. Theories-in-use are a kind of knowing-in-action and are usually tacit. However, theories-in-use can be constructed (or reconstructed) through "... reflecting on the directly observable data of ... actual interpersonal practice" (Schön 1987, 256). Argyris and Schön's "reflective practicum" through which they teach counselling and consulting skills is aimed at facilitating this process.

Schön (1983, 1987) cogently argues against the normative view of professional practice, in which formal knowledge takes precedence over knowing how and know-how takes the form of science-based technique. Schön counters this view with a proposal for professional practice in which practitioners operate openly, with congruency between their espoused theories and theories-in-use. In this revised view of practice, ones' theories-in-use are the subject of reflection, a kind of reflecting-in-action which "accounts for artistry in situations of uniqueness and uncertainty" (Schön 1983, 165).

In arguing for the interconnection of knowing and doing in a new epistemology of practice, Schön considers knowing-in-action to be tacit knowledge, implicit in patterns of intelligent, practical action. "[We] behave according to rules and procedures that we cannot usually describe and of which we are often unaware" (Schön 1983, 53-54). Schön's view that knowing-in-action is based upon rules and procedures fits with his understanding that practitioners are actors in a behavioural world, operating from theories-in-use which, potentially, can be articulated. (Schön 1987)

The second, and complementary path in Schön's argument is reflection-in-action, the holding of "reflective conversations" with one's own practice. He suggests that important to this process are the constants in an occupation: the media, language and normal repertoires that practitioners use to describe reality and

conduct experiments; the appreciative systems with which they frame and set problems; the overarching theory by which they make sense of phenomena, and the role frames within which they set their tasks. "They give the practitioner the relatively solid references from which, in reflection-in-action, he can allow his theories and frames to come apart" (Schön 1983, 270). Whilst the notion of reflection-in-action is a helpful one, Schön's use of it suggests that the process of reflecting-in-action is one of testing and revising one's theories-in-use.

Although his focus has changed slightly, Schön's recent works expand and deepen the theme begun in his earlier work with Argyris: that individuals use (implicit) theories-in-action, that theories can be constructed from an individual's knowing-in-practice, and that the individual's implicit knowledge can and should become explicit for the improvement of practice. This would happen through reflective conversation or reflection-in-action. However, despite the recognition of the tacit realm, and the importance of knowing-in-action, Schön maintains a view of the primacy of theory and a dichotomous view of the person and the world.

The notion of using knowledge permeates the literature on the theory-practice connection. It provides perhaps, the unifying tie. In the conventional position, the practitioner is viewed as an independent actor with a bag-full of knowledge to be applied or used selectively in specific situations. Theoretical knowledge is foremost: it is applied to practice by a thinking, knowing person (subject) in a separate, object world. A move away from the conventional view is made partially by Schön, but more so by Freidson and Benner. Benner perhaps goes farthest, in following Heidegger's (1962) turn to the primacy of practice, in which the subject/object dichotomy is eliminated.

It is timely to review some of the questions which remain about the nature of the connection between theory and practice. These questions are of particular interest when considering the interplay between knowledge and practice in everyday, moment-by-moment nursing practice. As theory is necessarily reductionistic, abstract and atemporal, how does it fit with the rich, ever-changing world of ongoing experience and practice? If formal knowledge changes in a context, as Freidson suggests, what happens in the transformation? Without a separation of subject and object can 'theories-in-use' be recognized in practice? What would influence the 'fit' of a theory, albeit a grounded theory, in a context outwith the

one in which it was generated? All of these questions suggest that the nature of the relationship between theory and practice is not only influenced by a view of theory but also by the view of the nature of practice and practical knowledge.

Practical Knowledge

Practical knowledge, know-how in everyday situations, is part and parcel of ongoing, everyday action. Practical knowledge is understandably overlooked by writers on theory in nursing (cf. Dickoff and James 1968, Jacox 1974, Meleis 1985), because it is often tacit (Polanyi [1958]1962), situation specific, taken-for-granted and part of our social background practices (Dreyfus 1980). In the currency of an occupation's "academic professionalizers" (Melia 1987), practical knowledge has a much lower value than formal knowledge. Knowledge which is practical, intuitive and experiential has lost ground in nursing to knowledge that is more scientific and theoretical. There are a number of possibilities why this might be so. Gordon suggests one:

Practical knowledge appears to symbolize a real and perceived nursing past characterized by subordination to physicians (as physicians' handmaidens), guided by obedience, habit, tradition or women's intuition. It recalls a time when nurses knew only how and not why. (Gordon 1986, 959)

Nursing is not the only occupation which has devalued practical knowledge. The recent efforts to describe the "personal practical knowledge" of classroom teachers is an attempt to redress the imbalance in education (Clandinin and Connelly 1987, Clandinin 1989).

In nursing, Benner provided the first extensive, systematic exploration of practical knowledge in clinical practice through the AMICAE Project (Benner 1984). This study of over 1200 nurses in the San Francisco area was originally designed to develop methods of evaluation for participating nursing schools and hospitals. The nurses provided critical incidents (Flanagan 1954) of their nursing practice. Additionally, 21 pairs of novice nurses and their experienced nurse preceptors were studied to ascertain the differences in clinical performance and appraisal of nursing care situations in which they were both involved and which stood out for them. Further interviews and/or participant observations were conducted with 51 experienced clinical nurses, eleven newly graduated nurses and five

senior nursing students to delineate and describe characteristics of nursing performance at different stages of skill acquisition. The data were analysed using an interpretative approach rooted in the work of Heidegger (1962), Rabinow and Sullivan (1979) and Taylor (1971). Arising from the data were areas of practical knowledge and domains of nursing practice, which will be addressed in another section.

Significantly, Benner's analysis does not separate subject/object, knowledge/practice. Practical knowledge, or "knowing how", according to Benner (1984), is the knowledge derived from experience, from the day to day business of caring for patients. Practical knowledge is embodied: it is the skilled know-how of the practitioner who has "knowledge in her fingertips" and comes from involved practical activity. It is everyday, ready-to-hand engagement with the world (Heidegger 1962). Practical knowledge is tacit or ineffable - that is, known, but not always capable of being explicitly described (Polanyi [1958]1962, 87). Indeed, "we can know more than we can tell" (Polanyi 1966). Practical knowledge is personal, but it is not necessarily subjective, private or idiosyncratic. It can be described and shared.

Central to practical knowledge is perception and a perceptual grasp (Merleau-Ponty 1962). For instance, we recognize a face directly: we do not analyze and add the various parts. Pattern recognition, the recognition of similarities and differences, is an essential part of 'normal' human life (Sacks 1985). Recognizing and understanding patterns stem from the social background practices which accrue through experience over time. They include understanding such things as the particulars of social space in different situations and the meanings of the phrasing, timing, tempo or intonation of words in particular contexts. An example of the nuances of practical knowledge which cannot be captured as acontextual, theoretical knowledge is my inability, after nearly four years in Scotland, to be absolutely sure when someone is saying, "no" in some social situations. The meaning of particular situations play an essential role in determining what counts in that situation and "it is precisely this contextual meaning that theory must ignore" (Dreyfus 1983b, 11). Not searching for theory, Benner (1984) identified areas of practical knowledge.

Areas of Practical Knowledge

Six areas of practical knowledge were identified from the critical incidents, interviews and observations of practice situations (Benner 1984):

1. graded qualitative distinctions
2. common meanings
3. assumptions, expectations and sets
4. paradigm cases and personal knowledge
6. unplanned practices

This listing provides a sense of the range of know-how, and illustrates how knowledge is embedded in clinical practice. Because of this value, an elaboration of the areas follows.

Graded qualitative distinctions are those fine differences in the perceptual grasp of a situation that experienced nurses have learned to make. This perceptual grasp is situation-specific and context-dependent. For example, subtle changes in a patient's wound drainage take on meaning only in light of the patient's current situation and history. Polanyi calls this subtle, perceptual grading, "connoisseurship", and notes that it must be learned through experience. It persists "because it has not been possible to replace it by a measurable grading" (Polanyi [1958]1962, 55).

Common meanings are developed by nurses working in similar areas with common issues about health and illness. They evolve over time and are shared among nurses. They are part of a tradition and are embedded in the language used by nurses in particular areas. Using the approach advocated by Benner to examine clinical knowledge, Olsen (1985) and Crabtree and Jorgenson (1986) have identified how death has common meanings for nurses within a specific specialty but that the meanings differ between specialties.

Death in oncology nursing is treated as a life event, and the role assumed by these nurses is one of making this experience as "good" as possible... Death...has been transformed in the I.C.U.; it has become a symptom, a harbinger of danger that

demands immediate response and treatment.
(Crabtree and Jorgenson 1986, 187-189)

Assumptions, expectations and sets imbue the contextual, narrative accounts of nursing practice. For example, assumptions and expectations about patient progress underly nursing actions, assessments and interventions. Assumptions and expectations may be evident to the outside observer and can sometimes be verbalized. Sets, "a predisposition to act in certain ways in particular situations" (Benner 1984, 7), determine how a nurse perceives and describes a situation. They are similar to Clark's (1989) "set of action beliefs and dispositions". Sets can never be made completely explicit while remaining unchanged. The act of uncovering them, bringing them to awareness, changes their function.

Through experience, nurses store and retain vivid memories of significant events. Benner (1984) coined them, 'paradigm cases', following Kuhn (1970). *Paradigm cases* are defined by Benner as:

A clinical episode that alters one's way of understanding and perceiving future clinical situations. These cases stand out in the clinician's mind; they are reference points in their current clinical practice. (Benner 1984, 296)

Benner contends that past situations stand out because they have changed the nurse's preconceptions and prior understandings - his or her personal knowledge. The transaction between this personal knowledge and the clinical situation determines the actions and decisions that the nurse takes. Benner's notion of paradigm case is directly linked to her understanding of experience, which "results when preconceived notions and expectations are challenged, refined, or disconfirmed by the actual situation" (Benner 1984, 3). We will be returning to the issue of the nature of experience and its link to the nature and role of paradigm cases in future chapters.

Benner describes *maxims* (Polanyi [1958]1962), as cryptic descriptions of skilled performance that can be understood by one who has enough skill and practical know-how to recognize the implications of the instructions. *Unplanned practices* occur when a nurse 'inherits' a new or risky procedure because the nurse is the one present at the patient's bedside when it needs to be done. The nurse 'improvises' and learns to perform this new skill.

Whilst these "areas of practical knowledge" are useful for becoming attuned to different ways in which practical knowledge can be exhibited and used, their conceptual inconsistency limit their use as a way to explore the everyday experience in nursing practice.

Researchers who have explored practical knowledge in nursing using a similar approach to Benner's (Brykczynski 1985, Olsen 1985, Crabtree and Jorgenson 1986, Fenton 1985, Diekelmann 1988) have extensively used the paradigm case as a unit of analysis. The researchers (cf. Fenton 1985) acknowledge that all of the nuances and the temporal nature of a situation can never be communicated but that the richness of practical knowledge can be conveyed through themes, examples, and maxims, and in person, by showing, feeling or pointing out smells.

In a contrasting experience, Elster (1987) admitted to having great difficulty in identifying Carper's (1978) ways of knowing in nursing practice using a traditional content analysis approach. She attempted to identify Carper's framework from an analysis of interviews with fourteen "excellent" nurses about their nursing practice. Elster found that when their words were taken out of context, their semantic variation was so great that classification was valueless. On the other hand, interpreting practical knowledge from the perspective of hermeneutic phenomenology (cf. Benner 1984), the knowledge embedded in practice is revealed and much of the context is retained.

In the section on learning and experience, it was shown that experience is often taken-for-granted in the quest to examine learning. Processes which enhance reflection on theoretical knowledge are emphasized and knowledge embedded in everyday practice and experience is overlooked. The separation of theory and practice parallels the separation of learning and experience. Yet experience is critical in the development of expertise. By examining some of the research on expertise, the nature and role of experience in the development of expertise can be considered further.

Approaches to Expertise

The terms 'novice' and 'expert' were first used by the cognitive science and artificial intelligence disciplines, and have been incorporated into the study of performance in other fields (Bereiter and Scardamalia 1986). Studying the contrast

between the knowledge and skills of experts and novices have yielded insights into thinking and decision-making skills. Glaser (1987) suggests that studies in cognitive psychology have found expert performance to be characterized by "rapid access to an organized body of conceptual and procedural knowledge". The process of decision-making, the nature of this "rapid access" and the knowledge which is used has been the focus of studies of clinical judgement in nursing (Tanner 1983, Tanner 1987, LeBreck 1989). Most studies have stemmed from the conventional approaches of statistical modelling and information processing (Tanner 1983, LeBreck 1989). But the studies' use of simulation and analytic procedures have been found to be of limited usefulness in describing clinical judgement in natural settings because practical knowledge and the influence of the context have been overlooked (Tanner 1989).

In a marked departure from conventional approaches, in the AMICAE study Benner (1984) explored the differences in practice between experienced and less experienced nurses using the Dreyfus Model of Skill Acquisition (Dreyfus 1982, Dreyfus and Dreyfus 1986). The Dreyfus Model was first developed during studies of airline pilots and chess players and, before Benner's study, had been extended to the study of automobile drivers and adult learners of a second language (Dreyfus and Dreyfus 1986). It is unique in its emphasis on the situation-specific nature of the knowledge inherent in expertise (practical knowledge) and the importance of experience in the development of that knowledge. Although the Dreyfus Model presents a unique approach to understanding expertise, it is not alone in recognizing the value of practical knowledge. Other researchers (cf. Pyles and Stern 1983, Isenberg 1984, Scribner 1986, Grant and Marsden 1988) have also begun to examine the contribution of practical knowledge to expertise and its development through experience.

The Dreyfus Model proposes that, in acquiring expertise in a particular field, people pass through five stages of qualitatively different perceptions of coming to the task and/or modes of decision-making. Expertise is developed along three dimensions: there is a shift from relying on abstract principles to perceive and interpret problems to using past experience as a base for judgement; there is a change from understanding parts of a situation and building a whole picture, to an immediate grasp of the whole situation; there is a shift from being detached and "outside" the situation to a stance of being involved in the situation. The

Model is sufficiently important to merit a fuller explication of the five levels: Novice, Advanced Beginner, Competent, Proficient, and Expert.

Level 1. NOVICE

At this stage, the individual has no background knowledge of the situation. The novice performer uses context-free rules to guide action. The rules are principle-based and theoretical, and concern the objective attributes of a situation.

Level 2. ADVANCED BEGINNER

At this stage the nurse has experienced enough real situations to note recurring meaningful components of the situation. The nurse operates with general guide-lines and needs help to set priorities. The advanced beginner cannot sort out what is important in complex situations and needs help in aspect recognition.

Level 3. COMPETENT

The nurse at this stage typically plans his or her care deliberately and consciously. These plans determine which aspects of the situation are most important. He or she is said to be able to "see the whole picture" or "be organized". There is a sense of mastery, of being able to manage or cope with many of the contingencies of clinical practice. The speed and flexibility of the proficient nurse is not yet there.

Level 4. PROFICIENT

Unlike the competent nurse who still perceives the situation in terms of its aspects, the proficient performer perceives situations as wholes. The proficient performer has an intuitive grasp of the whole based upon deep involvement and recognition of similar patterns. The nurse has experienced many such situations before. Setting priorities and making decisions is less laboured as the nurse recognizes which of the many aspects are most salient. He or she considers fewer options and is able to hone in on the most important region of a problem. Although there is intuitive, holistic recognition of the situation, the proficient nurse still needs to make decisions with detached calculation and reliance on a learned principle (maxim).

Level 5. EXPERT

The nurse operating at this level no longer needs to rely on operating principles (rules, guide-lines or maxims) to link recognition of the whole situation to appropriate action. The expert has an enormous reserve of experienced situations to draw on. He or she uses them to zero in on the accurate region of a problem and act. Not only is the perception of the situation intuitive, but so also are the decision and action.

Dreyfus and Dreyfus (1986) and Benner (1984) emphasize that these are stages of performance, not descriptors of people and that the stage of performance can change as the situation changes. However, in their writings, both Dreyfus and Dreyfus (1986) and Benner (1984) persist in naming people "experts" and "novices".

At the core of the Dreyfus Model is the movement from dependence upon theoretical knowledge to practical knowledge, from rational action to intuitive understanding. Dreyfus and Dreyfus (1986) propose that intuition is a central component of practical knowledge and is a key to expert clinical judgement. Intuition is defined as "understanding without a rationale". It is not however, an alternate form of cognitive skill (Rew 1986) or an unreliable, commonsense source of knowledge (Fishbein 1985). Dreyfus and Dreyfus (1986) note that intuitive judgement is characterized by six key aspects: pattern recognition, similarity recognition, commonsense understanding, a sense of salience, skilled know-how and deliberative rationality. Benner and Tanner (1987) have identified these aspects in their pilot study of expert clinical nursing decision-making. They also form the core of the Dreyfus Model's proficient and expert levels. Although action is discussed, it is often superseded by issues of decision-making. There is little explicit discussion by Dreyfus and Dreyfus or Benner of the process of developing physical abilities, or of the suitability of action to the situation.

A key issue which the Dreyfus Model does not sufficiently address concerns how people move from one level of skill to another. It is suggested that this movement happens by the "accumulation" of an immense "library of distinguishable situations" (Dreyfus and Dreyfus 1986, 32) which is built up on the basis of experience. They further suggest that people make a qualitative "jump" between stages, rather than progress in a linear fashion. But the nature of experience and the process of accumulation remains unexplored. Also needing further examination is the interplay between theoretical knowledge and practical knowledge during reflection.

The Contribution of Reflection

As it was earlier observed, reflection is central to the experiential learning models and to Schön's (1983) epistemology of professional practice. The actual process of reflection is variously described in the models, but commonly reflection is

deliberate, conscious, analytical and occurs outwith the flow of action. Schön contends however, that some practitioners integrate reflection into a smooth flow of action as reflection-in-action. Unfortunately, Schön's notion of action in practice is confusing as it encompasses both immediate and lengthy time frames. Schön suggests that reflection-in-action may occur over a number of minutes, or a number of months.

The process of reflection enters the Dreyfus Model in several ways. Up to the level of expert performance, reflection and planning is prior to and part of action. However, at the expert stage, reflection is retrospective: the expert acts intuitively, then critically reflects on those intuitions. Dreyfus and Dreyfus note how destructive it can be to fluid performance in familiar circumstances when the expert reflects prior to action. However, "when time permits and outcomes are crucial, an expert will deliberate before acting" (Dreyfus and Dreyfus 1986, 31-32).

Dreyfus and Dreyfus are particular about what type of reflection is most helpful in developing practical expertise. They contend that the mode of reflection changes with experience from "calculative rationality": objective, distanced and analytical, to "deliberative rationality": involved, synthetic and perspective changing (Benner and Tanner 1987). Deliberative rationality, a form of practical reasoning, consists of: contemplating the differences in the situation to account for the differences; focusing on the overall plan, noticing issues arising as the plan is played out; experiencing a change of perspective on the situation, so that new issues arise; considering the relevance and adequacy of past situations which seem to underly a current situation (Dreyfus and Dreyfus 1986). At the higher levels of skilled performance deliberative rationality or practical reflection is used to get out from "stuckness" (Persig 1974). Whilst Dreyfus and Dreyfus talk about the change of the nature of reflection with the stages of skill, in their discussion, the process of the change remains unclear.

Reflection of some form seems to be critical to the development of expertise. If reflection is as conscious and rational as some theorists lead us to believe (cf. Mezirow 1981), it should be able to be reported. However, there is some evidence to the contrary. In some studies of learning, people have been unable to give sensible reports of their learning from introspection (cf. Nisbett and Wilson 1977). As well, learning that occurs without conscious thought has been found to be inaccessible through verbal reports (cf. Bellezza 1986). Dreyfus and Dreyfus (1986,

40) suggest that for learning to occur a part of the mind must remain aloof, monitoring. But on rare occasions, during exceptional, fluid practice, monitoring ceases. The question remains about whether learning is occurring during such periods of fluid practice, and indeed what is the nature of experience during those times. It would appear, that like experience, reflection is something of a black box that we can speculate about but not entirely understand. This is particularly the case for reflection in everyday practice. If the view is taken, as do Dreyfus and Dreyfus (1986), that the conventional dichotomies between subject/object, action/reflection is misplaced when considering everyday practice and the development of expertise, the nature of the relationship between practice, practical knowledge and theoretical understanding remains problematic.

In summary, conventional approaches to the question of expertise have come from a perspective which accords primary value to formal or theoretical knowledge (knowing-that). In this perspective, theoretical knowledge, is usually seen to be used as an explicit guide to practice. Overlooked in this perspective is practical knowledge, or knowing-how. Almost singularly amongst the approaches to decision-making the Dreyfus Model of Skill Acquisition recognizes the contextual nature of expertise and the importance of practical know-how. The Model is also unique in its attention to the role of experience in developing expertise. Although Benner's research with the Dreyfus Model provides a good opening to the understanding of expertise in nursing practice, some problems and unexamined areas remain: the model focuses on the decision-making aspect of performance, and other areas of performance and their development are underemphasized; experience is considered to be relatively non-problematic; the nature of learning in the model remains underexplored.

CONCLUDING REMARKS

In this chapter, two bodies of literature have been reviewed: research on learning and experience and research on knowledge and the development of expertise. In the literature on learning and experience, it was seen that experience, though much discussed, is little examined, and when it is examined, is treated as a non-problematic, static entity. Learning was the focus of most of the studies, and the models developed from them. Those studies which used a phenomenological

approach, particularly those which concentrated on 'normal' learning experiences, considered experience more closely and revealed more of its complexity.

The conventional view of the link between theory and practice, in which theory precedes, and is applied in practice was explored and found to be wanting. An alternative approach to the link between theory and practice and the development of expertise, as exemplified by the Dreyfus Model of Skill Acquisition, was explored. This approach, which suggests that practical knowledge is primary, was shown to hold promise for illuminating the contribution of everyday experience to the development of nursing expertise. Of particular note was its concern with considering expertise in context. It is to nursing practice, the context of nursing expertise and experience that we now turn.

CHAPTER 3

NURSING PRACTICE: THE CONTEXT OF NURSING EXPERIENCE

Nursing practice provides the context for nursing experience and for the development of nursing expertise. The focus of this chapter will be on the depiction, in the research literature, of nursing practice, particularly the practice of ward sisters. Special attention will be paid to those studies which attend to nurses' experience in practice. Before turning to the research literature, it may be useful to recall why the study is focusing on ward sisters. As mentioned earlier, most of the nurses identified by the senior nursing managers as "excellent, experienced, clinical nurses" are ward sisters. The identification of clinical expertise at this level is consistent with the general view in the National Health Service. The ward sister (or charge nurse) is generally expected to be "... a role model for ward staff and a repository of clinical expertise" (Lathlean 1987, 16). This assumption of clinical competence permeates the ward sister literature, which concentrates, for the most part on the the management role, and stemming from it, the teaching role. Paradoxically, the clinical role of the ward sister remains little explored (Choppin 1983), overlooked and somewhat taken for granted.

The charge nurse/ward sister level is considered to be the first management level in the NHS (UK. Ministry of Health 1966, UK. Parliament 1979, Abel et al. 1986). It is the level where the clinical and managerial roles meet most sharply. The sister is the key figure in the ward team: she is responsible for overall planning and standards of care; the development of ward policies; delegating authority within the nursing team to facilitate work; assessment of patients' needs, setting objectives and monitoring progress (UK. Parliament 1972). The importance and influence of the ward sister in the ward, and the complexity of the role are recurring themes in research reports and reports emanating from committees, statutory and professional bodies. With continuing organizational changes, the complexity of the role is unlikely to diminish.

Nursing practice itself has been studied from various perspectives: the roles, tasks and activities undertaken by nurses, the process of nursing, the particular problems with which nurses are concerned, and most recently, the domains of

nursing practice (McFarlane 1989). This delineation provides a useful organizing framework for the discussion which follows.

NURSING ROLES: TASKS AND ACTIVITIES

Perhaps the first and most enduring approach to the study of nursing practice has been the description and analysis of tasks and activities. One of the first was the job analysis done for the Working Party on the Recruitment and Training of Nurses (UK. Ministry of Health 1947). Stemming from that report was Goddard's (1953) study of the work of nurses in hospitals which became a touchstone for other researchers. Goddard used quantitative work study methods to answer the question, "What is the proper task of a nurse?". For the purposes of task analysis, he categorized nursing duties into the following: 'basic' nursing, 'technical' nursing, administration and organization, domestic work and miscellaneous. "Basic" nursing care was originally defined as the care required for the physical comfort of the patient; "technical" nursing care included the tasks concerned "with the treatment of the disease from which the patient is suffering" (Goddard 1953, 37). These categories, sometimes with modifications, continued to be used over the next three decades by other researchers (cf. Revans 1964, Bendall 1975, Moulton, Melia and Hockey 1978, Fretwell 1982).

Bendall's research provides a useful illustration. To ascertain the relationship between knowledge and practice, Bendall (1973, 1975) extended Goddard's categories to study the activities of learners in the ward and compared these activities to what the learners said they would do in a given situation. Finding a very considerable discrepancy (73%), Bendall concluded that there was a marked conflict between the ideal and the real. Notwithstanding the potential importance of this difference, it is notable that Bendall did not question the adequacy of task analysis for depicting situational nursing practice.

The limitations of the task analysis approach was readily recognized by Goddard (1953) when he stated, "Any attempt to analyse this type of work inevitably results in a cold, calculated list of duties and fails to convey the atmosphere in which the duties are performed". He noted that this approach omits aspects of nursing work, for example, how nurses "exercise constant vigilance towards the patient's condition" (Goddard 1953, 25). However, the benefits of a scientific, "completely objective approach" were felt to outweigh these limitations.

A study to compare task and patient allocation systems of ward organization (Moult, Melia and Hockey 1978) identified the complexity of nursing care and the difficulties inherent in measuring nursing activity by means of rigid categories. Writing about this study, Melia (1979) suggested that a sociological approach, based on role analysis would be more fruitful. She proposed that the complexity of practice would be more readily captured by describing the nurse's role, where she worked and what kind of nursing skills she undertook in her day's work. To do this, more than observational task analysis would be needed. Accordingly, other researchers used more than task analysis in their studies of the role of the ward sister. But with only one exception (Runciman 1983), the researchers chose to focus on only one aspect of the role.

Ward Sisters: The Management Role

The Briggs Report (UK. Parliament 1972), among other studies, stressed the importance of ward management to the quality of nursing practice. Consistently with this view, in perhaps the most influential study of ward sisters in the U.K., Pembrey (1980) suggested that the exercise of the managerial role by the ward sister was crucial to the provision of individualized nursing care to patients.

Pembrey identified that those sisters who completed a four-stage management cycle in relation to each nurse and each patient ensured the delivery of individualized patient care. The management cycle consisted of: defining work (a nursing round of patients); prescribing work (written and verbal work prescription); delegating authority to work (allocation of work), and exacting accountability for work (accountability reports). An observational work activity analysis was used to examine the ward sisters' role differentiation. The second classification, of the work of the sister in relation to the ward management cycle, was derived from activity analysis as well as from qualitative criteria. Significantly, only nine of the 50 sisters completed all of the steps of the management cycle; a minority of the sisters completed any one of the four activities in the management cycle. The sisters who did complete the management cycle activities were said to manage the care on an individual patient basis. Whilst this study provides substantial insight into management activities, a view of the patient care which was made possible by these activities is not forthcoming. Additionally, Pembrey's study does not indicate that the sisters achieved multiple goals through seemingly mundane tasks, a phenomenon

which Runciman (1983) notes is prevalent in ward sister practice. Indeed, an activity analysis framework such as Pembrey's overlooks the goals which are inherent in nursing interventions (Glass 1983). Further, as Evers (1982a) points out, and Pembrey acknowledges, research such as this takes the ward and the patient for granted.

Education for the role reflects this emphasis on the management skills, and secondarily, on teaching skills. The Ward Sister Training Project, an experimental alternative to first line management courses was highly influenced by Pembrey's research. The "implicit notion of the scheme was the development of 'manager' sisters" (Lathlean and Farnish 1984, 3). While the programme was intended to emphasize the managerial role, in the evaluation of the project, Lathlean and Farnish (1984) acknowledge the important influence of the ward context on the nature of individual sisters' work.

Ward Sisters: The Teaching Role

The majority of studies of the ward sisters' role concerns the teaching component of that role, a concern not reflected in studies of North American or Israeli head nurses (cf. Hodges, Knapp and Cooper 1987, Bergman et al. 1981). It further highlights the different emphasis in the British nursing education system, where the learners are part of the work force and their clinical education and supervision is the responsibility of the ward sister.

McGhee (1961) and Revans (1964) were amongst the first to highlight the importance of ward sisters in determining the ward atmosphere and its influence on patient recovery. The influence of the ward atmosphere on student learning was explored by Fretwell (1978, 1982) and Orton (1981). Not surprisingly, the ward sister was found to be the most important person in setting the tone for learning in the ward. The ward sister "is the person, above all, responsible for the climate of her ward" (Orton 1981).

Fretwell's (1978, 1982) study attempted to describe and analyse the teaching/learning situations in hospital wards, and to identify the characteristics of a "good" ward learning environment. Activity analysis was again a central part of the research method. In the first stage of a two stage project, 327 students rated wards as good and less good wards. From these ratings, Fretwell constructed

characteristics of an "ideal" ward learning environment. On the ideal ward, sisters and trained nurses: show an interest in the learner when she starts on the ward; ensure good learner/staff relationships; are approachable and available, pleasant yet strict; promote good staff/patient relationships and quality of care; give support and help to learners; invite questions and give answers; work as a team.

For the second stage, Fretwell created three high/low pairs of wards from the student ratings. Nursing activities of students were sampled and analysed using categories modelled on systems used by Goddard (1953) and Bendall (1973). Analysis of ward sister activities were developed from a system suggested by Inman (1975). Fretwell found differences in ward learning environment to be partially related to the sisters' leadership style, which she termed: autocratic, democratic or laissez-faire. To further explain the differences, Fretwell used Bendall's (1973) notion of ward sister orientation: how the sister spent her time and to whom she gave priority. Bendall had identified two orientations: patient orientation or doctor orientation. Fretwell added a third, administration orientation. To measure ward sister orientation, Fretwell turned again to activity analysis, this time ten-minute activity sampling, augmented by qualitative data which was collected during "key" events.

Fretwell found that an ideal learning environment is created by the sister and is characterized by teamwork, negotiation and good communication. She suggests that the sister who is democratic, patient-orientated and sees the students as learners rather than workers can create such an environment. "Those wards in which learners learn a lot are those wards in which sisters make a conscious effort to make teaching a reality" (Fretwell 1982, 111).

Something of the complexity of the sisters' role comes through in this study, but the contextual nature of both the students' and sisters' practice is missing. The separation of nursing care into activity categories only reflects what tasks are apparently being done. The intention, the goal, the complexity of decision-making and the process of practice are all overlooked in this approach. This separation of activities and tasks runs the very real risk of perpetuating the perception of a hierarchy of skills, with technical skills being more valuable than basic skills (McFarlane 1976).

Students' perceptions provided most of the data for two further studies which examined the ward sisters' role in creating and maintaining an effective learning climate. Orton (1979, 1981) found that the ward learning climate is a "property of the environment" and exists as a "psychological reality" for student nurses. On the basis of student responses to two scales which asked about activities and attitudes, Orton was able to discriminate between wards with "high student orientation" and "low student orientation". This discrimination was confirmed by questionnaire data from the sisters indicating where they actually do spend their time and where they would like to spend their time. Hallmarks of a high student orientation ward were a combination of good patient care, teamwork, consultation and awareness by the ward sister of the needs of her subordinates.

Ogier (1982) sought to develop grounded theory about the leadership style and verbal interactions of ward sisters with nurse learners. She studied the verbal interactions of four ward sisters with nurse learners over the period of a week. The interactions were examined for content and speech form and compared to the results of questionnaires completed by learners about their perceptions of the ward learning climate. Again, a favoured leadership style was identified: one in which the ward sister is approachable, learner-orientated and sufficiently directive for the nature of the work. Seven years later, these findings were confirmed by a smaller replication study (Ogier 1986). While both Orton's and Ogier's studies cast some light on aspects of the ward sister role and identify positive attributes of the ward sister, little light is shed by these studies on the actual practices of ward sisters.

In a somewhat differently designed study, Marson (1981) sought to isolate those behaviours of ward teachers (nurses, sisters and others) considered by trainee nurses to help them to learn from work experience. Her study was completed in three phases. The first phase included structured interviews with learners and ward sisters to ascertain perceptions of teaching and learning, and to obtain a description of the behavioural characteristics of a "good ward teacher". The second phase sought to test the "good teacher" findings with a larger group of learners. It is notable that learners did not respond to a request to provide critical incidents of effective learning experiences and Marson replaced this technique with a questionnaire. The third phase consisted of structured observations of verbal interactions and observations of nursing activities. Although she replicated many of the findings of Orton's, Ogier's and Fretwell's research,

Marson more clearly than the others, identified that "on the job" teaching is a complex global act. She further noted that how the nurse (ward sister) is in practice is critically important when it comes to learners' experiences. Again, however, the context and content of nursing practice were not captured by activity analysis and this phenomenon of "being a nurse in practice" could not be more fully explored. Marson herself recognized this need and recommended that further research occur into what students learn and how the qualities of good ward teachers can be conveyed to others. Robinson and Elkan (1989) note that these recommendations remain as current as they were when Marson wrote them in 1981.

Ward Sisters: The Clinical Role

As mentioned earlier, the ward sisters' clinical role is so central that it usually taken for granted and remains in the background of most of the ward sister studies. When the role is discussed, it is often in terms of setting and ensuring standards for care (cf. RCN 1981). There is little direct examination of the clinical role itself. Part of the lack of attention may stem from different understandings of the clinical role and its importance.

In a study of the attitudes and activities of ward sisters, undertaken as a precursor to a management training programme in one hospital in Wales, Williams (1969) found that senior nurses attached more significance to the sisters' management responsibilities. On the other hand, the sisters attached more significance to their clinical responsibilities. Williams describes the sisters' role as having a clinical core: "a small kernel of purely professional activity", surrounded by layers of activities which are progressively more managerial. While the clinical activity is central, this metaphor may not be particularly apt, as managerial, clinical and teaching activities would not necessarily be "layered". And the impression given by a few other studies (cf. Runciman 1983, Marson 1982), is one of integrated activities.

The centrality of the clinical role is also implied in suggestions that the ward sister is a role model for nursing staff and learners (cf. Marson 1981, 1982, Allen 1982). As the learners, in particular, are learning to give direct care, it can be assumed that the ward sister is modelling clinical care, rather than management or

teaching. Another, more likely possibility, sees the sister modelling integrated, complex practice.

It is of interest that one of the clearest statements about the ward sisters' clinical role comes from consultants. In the preparatory phase of a ward sister training programme, Allen (1982) asked consultants in participating training wards for their expectations of the ward sisters. Amongst the responsibilities the consultants attributed to the ward sisters were: smooth running of the ward and reasonable quietness in the ward; comfort and well being of patients; day to day management of food, bowels, sedation, analgesia and general activity; communication with patients' relatives concerning details of the patients; arranging appropriate access for patients and relatives to consultant and junior medical staff. This of course, gives only one view of the role of the ward sister, but it is notable that it is a clinically-focused view.

A link between the ward sister's conceptual approach and the outcome of care was made in Kitson's (1984, 1986) study of the quality of care on geriatric wards. Again activity analysis was the mode of choice for objectively assessing practice. However, unlike other studies, the researcher made qualitative judgements about the suitability of the nurses' actions. Nurse-patient interactions were analysed and judged to be therapeutic or non-therapeutic. The therapeutic goal was to achieve optimal self-care and independence. The scores on this set of measures, the Therapeutic Nursing Function Matrix, were explained by the ward sisters' TNF Indicator: a self-administered questionnaire designed to identify aspects of organizational ability, knowledge and attitudes towards care. Kitson found that more therapeutic nurse-patient interactions occurred on wards where the ward sister had a patient-centred or therapeutic nursing care outlook. A major drawback of the study, which Kitson recognizes, is that the research tools are in the developmental stage. Remaining unexamined however, are the method of judging quality and differences in competence amongst nursing staff. Although the quality of care is addressed, the context of the situation in which the interactions occurred remains hidden.

Roles and Work

Other studies of the ward sisters' role and the nature of nursing work provide important insights into nursing practice. Redfern (1981) and Runciman (1983)

studied the role from the sisters' perspective. Redfern's (1981) study of sisters' job attitudes highlighted the complex of stresses and conflicts inherent in the role. She found that sisters derived the greatest satisfaction from aspects intrinsic to the work itself, such as helping people. Organizational factors provided the greatest source of dissatisfaction.

In a study which sought depth rather than breadth, Runciman (1983) studied the role from the perspective of problems experienced by nine ward sisters. She undertook an activity analysis over 28 hours of observation with each sister, gathered information about the sisters' self-perception through a semantic differential and short interview about a shift, and interviewed each at length around problem statements. Unlike the other studies, Runciman highlights the difficulty of identifying and coding units of behaviour because of the complexity of the ward sister actions. Through her examples, Runciman depicts the contextual nature of the sisters' actions and problems and acknowledges the sisters' emphasis on their clinical management role. Runciman's study is particularly helpful for revealing the important and recurring problems of ward sisters' experience in practice, such as interruptions and handling conflicts. However the sisters' practice in its ongoing context remains somewhat hidden.

A number of studies using sociological approaches consider the wider context of nursing, including the complex social relationships in a nursing ward. As Evers (1982b) suggests, these studies give insights into the social processes in nursing practice. Strauss et al. (1985), for example, describe a number of different dimensions of nursing work and how it is carried out. Smith (1988) describes nursing work in terms of emotional labour and links it to the quality of care in a ward. In these studies, the work is separated from the people who do it and the particular ongoing situations in which the nurses practice. For example, Smith (1988) talks about nurses "doing" emotional labour and technical labour. There is a distinct separation of subject and object, an instrumental approach is taken to practice. Like the sociological studies of experience and learning, these studies quickly move from the starting point of the subjective experience of the person to an explanation of the social world. They leave unexplored the relational nature and meaning of ongoing practice.

The studies of nursing roles, for the most part have concentrated on a delineation and exploration of nursing activities and tasks. A few studies have considered the social context and the social processes of nursing work. Overlooked in these approaches are: the ongoing context of practice of which tasks are but a part; the goals and meaning of practice; the knowledge and decision-making skills required to care for patients in an appropriate and timely manner; the interconnected nature of the individual and the social world. The move to reclaim nursing to be caring (cf. McFarlane 1976, Roach 1987, Benner and Wrubel 1989), stems in part, from recognizing the inadequacy of depicting nursing practice as simply an amalgam of activities or tasks, separated from the meanings and context within which it happens.

NURSING PROCESS

The nursing process, "a planned, systematic approach to the care of the individual patient" (UK. DHSS 1986) has been established as a principle of good nursing (RCN 1980, RCN 1981). Usually, the nursing process is said to consist of four or five stages in a problem-solving process: assessment, diagnosis, planning, implementation and evaluation. The literature on nursing process is wide ranging as the nursing process has been taken to mean an organizational approach to care, as well as an individual nurse's approach to the care of an individual patient. Included in this range of literature are studies on the knowledge and skills needed for the nursing process, implementation of the process, and underlying communication processes and systems. Research on implementation of the nursing process has included studies on organizational changes, changes in method of work assignment from task to patient assignment and changes in documentation. These studies will not be explored in this review as they emphasize the organization of nursing practice. More insight into individual nurses' practice is afforded by research on the generic skills and processes which are held to be necessary in order to implement the nursing process (cf. UK. DHSS 1986): interpersonal relations, communication, clinical decision-making, psychomotor skills and measurement skills.

As mentioned in an earlier section, a concentration on the process of decision-making, because it is decontextualized, gives only a limited insight into the nature of practice (cf. Tanner 1983). This is no less so for nursing diagnosis (cf. Gordon 1985, Kim 1989) and nurse-patient interaction and communication (cf.

MacLeod Clark 1982). Lelean's (1973) study will serve as a good illustration of the potential and limitations of studies of communication to shed light on the complexities of nursing practice.

Lelean attempted to measure the effectiveness of formal communication between ward sisters and nurses in regards to patient care. Eight categories of "nursing care items" were studied: mobility, toilet, period up, washing/bathing, feeding, turning, blood pressure and four-hourly T.P.R. The ward sisters' ratings of the patients' needs for these items on a patient dependency form was compared to observed nursing care, to see whether the nurses were doing what the sister thought they should be doing for the patients. As well, the ward sisters' instructions were compared to observed nursing care. The findings included the amount and duration of the sisters' communication with various groups of staff, and theirs with the sisters. Lelean confirmed Revans (1964) and others findings that the ward sister was "*the key person on the ward controlling all communication coming into and going out of the ward as well as that within the ward itself*" (Lelean 1973, 102).

The limitations of gaining a view of nursing practice through an analysis of a part were exemplified by the difficulty in classifying the sisters' instructions in a reliable manner. This difficulty was such that Lelean was unable to compare the instructions with the observed nursing care. For example, "mobilize" had six different meanings and could mean two different things in one day. The consistency between the dependency assessments and observed nursing care in certain categories showed that there was shared meaning around some instructions. While Lelean's method allowed for identification of a range of meanings and highlighted the imprecision of both verbal and written instructions, it precluded an examination of the meaning of the instructions in particular situations.

Such an acontextual treatment of the study of communication patterns is not uncommon (cf. MacLeod Clark 1982). While these studies provide valuable insight about specific components of nursing practice, in their search for general, acontextual knowledge, they are confined to a limited, often deficit view of nursing practice.

PROBLEMS AND CONCERNS OF PRACTICE

An increasing number of studies are examining clinical phenomena (Loomis 1985, Brown, Tanner and Padrick 1984). In these studies, the focus is on problems such as pain (cf. Seers 1987), the experience of patients recovering from surgery or illness (cf. Webb 1984, Ford 1989) or specific nursing interventions (cf. Hayward 1975, McHugh, Christman and Johnson 1982). Although these studies of the quality of nursing care are, as McFarlane (1970, 11) suggested, "intrinsically valuable for the light they throw on nursing practice", they provide a better view into the phenomena of concern to nurses than they do into nursing practice itself.

For instance, Seers' (1987) study sought to examine the factors affecting pain, pain relief, anxiety and recovery in patients undergoing elective abdominal surgery. Patients were interviewed preoperatively and fourteen times postoperatively. Nurses caring for the patient rated pain and pain relief on a verbal rating scale; recovery was estimated daily and trained nurses were asked for their opinions on postoperative relief. Although this study provided rich data about the control of post-surgical pain and the consistencies and discrepancies between nurses and patients' ratings, the practices of the nurses are only partially revealed. Missing are the important contextual aspects of their practice in specific patient situations.

Inman (1975), in her assessment of the studies in the Study of Nursing Care project, noted the need for a more comprehensive study of the situational nature of nursing practices. While the studies (for example, Hayward 1975) were successful in examining the objective aspects of nursing care situations and the attributes of nurses giving care, they were not as successful in addressing the contextual nature of that care and the effect of its situational nature on the quality of nursing care.

Missing too, from these studies and others is an explicit recognition that nursing practices and the quality of care are affected by the competence of the person giving that care (Benner 1984). This oversight is of particular importance when considering the British nursing studies. In almost all of these studies, much, if not most of the nursing care was provided by untrained nursing staff: students, pupils or auxiliaries. The picture presented is the nursing care of inexperienced, not-yet fully competent practitioners, an important consideration when the view presented is a general view which highlights what is not there (cf. MacLeod Clark

1982). Unfortunately, the practice of experienced, accomplished nurses is not generally evident.

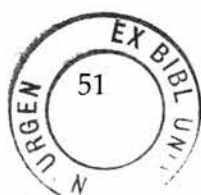
NURSING PRACTICES

It was said earlier that Benner (1984, Benner and Wrubel 1989) takes a marked departure from previous ways of studying nursing practice. Notably, Benner stresses the importance of recognizing that nursing practice happens in an ongoing situation; that the apparently intuitive, taken-for-granted practices have, embedded in them, sophisticated knowledge and skills. This knowledge and skill, this practical know-how, is formed and reformed in the ongoing situation. Therefore nursing practices must be studied in their ongoing situation.

In the discussion thus far, a distinction has been made between nursing care and nursing practice. Nursing care refers to specific actions or complexes of actions which nurses perform, while nursing practice concerns the exercise of nursing care. Nursing care is the 'what'; nursing practice combines the 'what' with the 'why', the 'how', the 'when' and the 'where'. Using an interpretative strategy which focuses on meanings as a way of organizing and describing practice, Benner attempts to depict the process, content and context of nursing practice. The context of practice includes "the timing, meanings, and intentions of the particular situation" (Benner 1982, 306).

In the AMICAE Project which was described in an earlier section, Benner (1984) inductively identified 31 nursing competencies. She suggests that these competencies, which are not adequately identified by their labels (e.g., Providing comfort and communication through touch), can only be understood by reference to their contextual examples. The competencies were organized into seven domains of nursing practice:

1. The Helping Role
2. The Teaching - Coaching Function
3. The Diagnostic and Patient Monitoring Function
4. Effective Management of Rapidly Changing Situations



5. Administering and Monitoring Therapeutic Interventions and Regimens
6. Monitoring and Ensuring the Quality of Health Care Practices
7. Organizational and Work Role Competencies

Others have used Benner's interpretative approach to study nursing practice. Fenton (1984, 1985) studied masters prepared nurses; Brykczynski (1985), nurse practitioners; Olsen (1985), oncology nurses; Crabtree and Jorgenson (1986), intensive care nurses. Through their interpretation of paradigm cases, Olsen and Crabtree and Jorgenson confirmed the domains of practice and many of the competencies in them. Fenton (1985) and Steele and Fenton (1988) added the domain of "The Consulting Role", from their study of clinical nurse specialists. Brykczynski (1985) interviewed and observed 22 nurse practitioners in an ambulatory care setting. She combined two domains: the "Diagnostic and Patient Monitoring Function" and "Administering and Monitoring Therapeutic Interventions", incorporating them into a new domain for ambulatory care: "Management of Patient Health/Illness Status in Ambulatory Care Settings".

It is apparent in these studies, that although most domains of practice are common to all areas of nursing, the specific character and emphasis of the domains differ among specialty areas and among nurses in different roles. Notably, the participants in all of these studies, except Brykczynski's, were identified as experts according to the criteria used by Benner (1984, 15). The nurses had had at least five years of clinical experience, were currently engaged in direct patient care, and were recognized by their peers and others as being highly skilled clinicians. It would be interesting to see whether the domains of practice and competencies would differ among nurses of lesser competence. As they are inductively derived from specific nursing contexts, it could be expected that the domains and competencies would differ among countries as well.

Although the description of competencies and domains, with their accompanying examples, depict the context, content and process of nursing practice, Benner's taxonomic framework does not depict the care of groups of patients. This problem is addressed in *The Primacy of Caring*, (Benner and Wrubel 1989), in which nursing practice is explored in relation to the "lived experience of human illness and the relationships among health, illness, and disease". The practices of expert

clinical nurses, characterized as caring practices, help patients to cope with the stress of illnesses such as neurological disease, coronary illness and cancer. Caring practices, as described by Benner and Wrubel, are always understood in a context: they are specific and relational.

One disadvantage of Benner's approach is that the view of nursing practice is always through the nurse: the research material, the interviews and paradigm cases come from the nurses. The patients' understanding of and actions in the situation are revealed only through the nurses' accounts. Participant observation, which holds a promise of affording a broader perspective, has been used by Benner and others, but it seems to play a secondary, confirming role. However, it is interesting that in *From Novice to Expert*, a number of the examples concerning such things as the hazards of immobility are from participant observation field notes. This pattern of exemplars is not explained. Benner concedes that a bias towards the dramatic and poignant, at the expense of the mundane, exists in the research material because of the research strategy asking for "outstanding clinical situations" (Benner 1984, xxii). Additionally, because the research approach seeks to describe skilled practice, deficits do not come into view. What is there, is studied, what is not present receives lesser attention (cf. Fenton 1984, 1985). However, despite these drawbacks, Benner's approach, with its concentration on the particulars of practice in specific contexts, seems to be more successful in depicting the complexity of nursing practice than previous approaches.

In addition to the studies which have approached nursing practice from the perspective of hermeneutic phenomenology, a few other researchers have examined nurses' subjective experiences using more traditional phenomenological approaches. For example, Field (1981) examined nurses' experiences of giving an injection, and Forrest (1989) explored seventeen hospital staff nurses' subjective experience of caring. These studies do contribute important insights to the understanding of nursing practice. However, like the studies of the experience of learners which take a traditional phenomenological approach, they maintain the subjective/objective dichotomy. In addition, the categories and themes which are developed from the material are somewhat abstract, and the situational and relational nature of nursing practice is not as fully developed as it might be.

In these phenomenological studies, and in those using hermeneutic phenomenology, the nurses' experiences, related in interviews or written in essays or paradigm cases, are treated non-problematically. The researchers are interested in the content of the experiences; on interpreting the "meanings, situations, practices and bodily experiences" (Benner 1985), or extracting and "formulating meanings" (Forrest 1989) from the descriptions of lived experiences. In the studies' discussions about method, the form of the experiences are not examined in depth. Once in textual form, the experiences appear to be treated rather like vessels of feelings and meanings, albeit vessels which hold experiences which have taken place over time. This issue, about the form and nature of experience will be discussed in later chapters.

CONCLUDING REMARKS

In summary, the context of experience and expertise in nursing, nursing practice, has been studied from several perspectives: work roles, tasks and activities; the process of nursing; problems of concern to nurses, and practice as it is experienced by nurses. It was shown that nursing practice has a history of being studied from a number of perspectives which fracture its various parts and fail to capture and convey its complex, contextual nature. This is particularly so for a role like the ward sister. In particular, the clinical component of the ward sister role, while central, has been taken-for-granted and is often overlooked. Benner's approach to the study of nursing practice, which examines practice from the vantage point of experience holds promise for capturing its contextual, relational, complex yet particular nature. It would seem that in order to explore everyday experience in nursing practice and its contribution to the development of nursing expertise, a similar approach might be in order.

CHAPTER 4

APPROACH TO THE STUDY

The approach taken in this study lies within the interpretative tradition, a tradition which seeks to understand meaning in human experience. The particular form of an interpretative study is determined by a number of factors. Among them are: the particular strand of the interpretative tradition which informs the study, the nature of the substantive concern, the contingencies of the research situation and the capacities and inclinations of the researcher. More specifically, this study has been informed by hermeneutic phenomenology, a strand of the interpretative tradition which follows Heidegger's (1962) ontological turn. The everyday experience of surgical ward sisters, as expressed in their accounts and observed in their ongoing practice provided the material for interpretation. In this qualitative form of research, the researcher is thus, far from invisible. More than just a 'research instrument' (Sanday 1979, Guba and Lincoln 1981), the researcher is influential in all stages of the study. Inevitably then, my own experiences and skills have been drawn upon, tested and extended through this study. Their influence on the course of the research will be discussed throughout this account. Before moving to the specifics of the study, however, it may be useful to give a brief overview of the central themes in the interpretative tradition as well as the particular perspective afforded by hermeneutic phenomenology.

THE INTERPRETATIVE APPROACH

The interpretative tradition can be traced to Dilthey, who first attempted to create a distinctive method for the human sciences by proposing that understanding has its roots in the process of human life itself. According to Dilthey, in the course of everyday life we humans have to make sense of the situations we are in, so we can act accordingly. These acts of understanding (*Verstehen*), which are lived by us, constitute our "lived experience" (*Erlebnis*). In turn, the manifestations of human life: words, gestures or actions, what Dilthey called the various forms of "life expression" (*Lebensäußerung*), point back towards lived experience as their source. Hence, for Dilthey, and then Weber, the understanding sought by social scientists referred to a deep level of comprehension, involving capturing the

expressions of "inner realities" (Giddens 1982). It can be seen then, that central to this notion of *Verstehen* is grasping the subjective meaning of a person's action from the actor's point of view.

Husserl's foundational work provided Dilthey with a phenomenological viewpoint from which to develop his hermeneutics for the social sciences (Mueller-Vollmer 1985). Within Husserl's philosophy, phenomenology sought a solid foundation for knowledge by analysing consciousness and its objects in direct experience. He proposed that all forms of knowledge have their roots in consciousness: consciousness is intentional, that is, it is consciousness of something. Husserl argued that in our direct experience of the world, we suspend our presupposition of an object's reality; we constitute matter/objects in our consciousness of them. This process, of stepping into a philosophical attitude, of distancing oneself from commonly held understanding about the phenomenon in question, Husserl called 'bracketing'. Bracketing our presuppositions about objects of consciousness allows us to come at the phenomenon freshly - to examine them as they are constituted in our mental content. This concentration on subjective experience is at the heart of Husserl's work. Both Dilthey and Husserl, continuing the philosophical tradition of Descartes, understood humans to be subjects in an object world: "... spectators, observers, separated by an invisible plate-glass window from the world of objects in which we find ourselves" (Magee 1987, 258).

This distinction between subjective experience and the object world has been maintained in various strands of the, by no means coherent, interpretative tradition which has been highly influenced by the work of Dilthey and Husserl. Among the most influential approaches in nursing and education have been social phenomenology (Schutz and Luckmann 1974, Berger and Luckmann 1967), ethnomethodology (Garfinkel 1967) and the symbolic interactionist approaches of Mead (1934) and Blumer (1969). These divergent approaches, while having considerably different views of experience, meaning, and the nature of the person and their context, nevertheless consider the person and the world to be separate though closely interrelated entities. The phenomenological tradition, largely shaped by Husserl's work, and sometimes described as a descriptive approach (cf. Spiegelberg 1982, Omery 1983, Munhall and Oiler 1986), is represented for the most part in studies in nursing and education by the approach taken by Giorgi

(1975, 1985) and van Kaam (1959), among others. This approach has concentrated on providing rich descriptions of people's subjective experiences.

As we have seen in Chapters 2 and 3, the studies in nursing and education which have been based on these approaches have provided a wealth of information about the experiences of learners and the world of learning, and of specific aspects of nurses' experience in practice. However, it could be fairly said that some of the studies' shortcomings, namely, the inability to adequately capture the complexity of nursing practice, the inability to grasp ongoing experiencing as well as past experience, and the oversight of the inseparability of the person and their context, could be traced to the studies' philosophical underpinnings. These shortcomings, it was noted in Chapters 2 and 3, were not as pronounced in the interpretative studies (cf. Gray-Snelgrove 1982, Benner 1984) which followed the turn in phenomenology taken by Heidegger.

The phenomenological turn taken by Heidegger and augmented by Gadamer and Ricoeur points the researcher towards not only a different approach to analysing the research material, but also towards a different focus of concern in fieldwork. The central, relevant themes in Heidegger's major work, *Being and Time* (Heidegger 1962) are explored next.

Hermeneutic Phenomenology

Heidegger, himself drawing on Dilthey and Husserl, proposed that the questions they were pursuing, about how people *know*, were only secondary to a consideration of how people *are* in their everyday endeavours. If one looks beneath to the human situation, it does not appear to be a situation in which a conscious, autonomous subject is directing his mind to mental representations of the world. While we may consciously direct our minds towards objects, it is only possible because we are already beings who are coping in the world. This irreducible connection between being and the world is reflected in Heidegger's starting point, which is not the separate person or subject, but is rather *Dasein* which, roughly translated, means existence or 'being-there'.

Dasein is not seen as a conscious subject, a self-contained source of meaning-giving consciousness but as an individual dependent upon shared, taken-for-granted, background practices for the content of life and for all meaning and

intelligibility. That is because "*Dasein* always understands itself in terms of its existence" (Heidegger 1962, 33). In *Being and Time*, Heidegger explores these ways of Being. What is notable about the ways of Being of *Dasein* is that they are all ways of comporting, of being-in-the-world.

The 'world' for Heidegger is not an impersonal, objective world, but rather is closer to a personal world which cannot be conceived as separate from the self. Heidegger shows in his phenomenological analysis of *Dasein* that there is no subject-object delineation prior to knowledge of the self in the world or knowledge of the world as present without the self. Our world, Heidegger proposes, is made up of background practices, social practices and historical contexts. It is unobtrusive, presupposed and is usually transparent to us (Dreyfus 1983a). Heidegger says that we dwell in the world - we inhabit it. When we inhabit something, it becomes part of us and pervades our relation to other objects in the world (Dreyfus 1983a, V-6). In this way, for instance, we inhabit our language. We are at home in it and relate to other people and objects through it.

In the same way that the world is unobtrusive, so are our tools and the practices that we undertake without thought. Heidegger proposes that people have three distinct, yet interrelated modes of engagement, or involvement, with objects in their world: ready-to-hand, un-ready-to-hand and present-at-hand. In the ready-to-hand mode, people are actively engaged in practical projects - objects are taken for granted. There is no conscious awareness of the activities as separate events or parts. There is unthinking, holistic awareness, a concerned absorption. Common, everyday practices are taken for granted - they are so familiar. Only when there is an interruption or problem in the smooth flow of activity, does the person disengage from this mode.

Meeting a problem or experiencing an interruption in the smooth flow of practical activity, and moving to an awareness of the problem is the mode of un-ready-to-hand. The breakdown of action is noticed, it becomes salient, but our noticing of it remains within the context of the background of activity in which we are engaged.

We enter the present-at-hand mode when we step back from involved activity to reflect upon it. The ready-at-hand phenomena in the world which previously we

did not see, are brought into view through the mode of presence-at-hand (Heidegger 1962, 102-105).

Although the social world is not specifically addressed as such in *Being and Time*, *Dasein* is already socialized into background skills and cultural knowledge. From birth, we live and learn within practices that contain an interpretation of what it is to be human in our culture. Thus, we learn what it is to be a person within our historical, cultural and social context. As well as learning what it is to be, we learn what an object is and how objects are to be related to. Our understandings of what it is to be human fit together with what it is to be an object. Both are aspects of a more general understanding of Being within a particular culture (Dreyfus 1983a, II-9). Rather than being a separate mind, needing connection with other minds, *Dasein* is already being-with others, sharing the background understandings and culture. The shared taken-for-granted background makes understanding possible, but as each of us has differing experience and differing histories, all is not shared and times of misunderstanding are inevitable.

Before moving on to a discussion of how this approach of hermeneutic phenomenology affected the evolution of the study, specific reference must be made to the notions of understanding and interpretation which inform this study. They are of particular importance because of the concern in this study to uncover what is usually hidden from us, the nature of everyday experience in nursing practice.

Both 'understanding' and 'interpretation' are words that have specific meanings within Heideggerian phenomenology. For Heidegger, understanding is the power to grasp one's own possibilities for being, within the context of one's world. To use an often quoted example of Heidegger's, the practice of hammering only makes sense in terms of nails, wood, and wooden structures, equipment which Heidegger calls the totality of significance. This relational structure of the world, in turn is only possible because of the skills such as holding objects, wearing clothes, walking and moving which have enabled me to get to the position of hammering. This context of assignments or references, the taken-for-granted background of the world and my capacities for being in the world, is what is disclosed in understanding.

Understanding, for Heidegger, is an ontological process, a disclosure of what is real for persons. It is not merely a conscious or unconscious process.

It is not a special capacity or gift for feeling into the situation of another person, nor is it the power to grasp the meaning of some "expression of life" on a deeper level. Understanding is conceived not as something to be possessed but rather as a mode or constituent element of being-in-the-world. (Palmer 1969, 131)

As a central constituent of being-in-the-world, understanding has a temporal sense. According to Heidegger, we are temporal beings. Our temporality shows itself in our ongoing activity and practices. Time could be said to be *in* the activity. Being in a situation, we act from the past, in the ongoing present, but always projected towards the possibilities of the future. Our horizon of understanding, which embodies this temporality, is one of projection. It is explicated through interpretation. Interpretation in turn, always presupposes meaning and understanding. There is no hope of presuppositionless interpretation. "In every case this interpretation is grounded in *something we have in advance - in a fore-having*" (Heidegger 1962, 191). This fore-having is the background of meaning and experience embedded in our practices, language and history. It forms our "horizon" for interpretation.

Heidegger suggests that interpretation is central to our constitution in the world: *Dasein* is self-interpreting. We understand ourselves in some specific way. "It is interpretation all the way down" (Dreyfus 1983a, III-6). Heidegger contends that this understanding of self is not totally available to us. Our background meanings and pre-understandings, our interpretations of being-in-the-world are inaccessible to us, concealed through our everyday existence.

Heidegger's example of a hammer illustrates how we only become aware of our practices and the meaning of them when some breakdown occurs (Heidegger 1962). A hammer that is merely present, can be weighed, catalogued and its properties assessed. However, the meaning of the hammer is not disclosed through mere contemplation. A hammer needs to be used to display its aspects in a functional context. However, when breakdown occurs, when the object moves from being ready-to-hand to unready-to-hand, the meaning of the object or practices are highlighted; they emerge from their everyday background of

unobtrusiveness. When the nail does not go in smoothly, the hammer ceases to be a taken-for-granted tool and it may be interpreted as being too heavy for the job at hand.

This example suggests a hermeneutic principle, that through interpretation, the being of something is disclosed when it emerges from the background to the full functional context of the world (Palmer 1969, 133). Thus, the act of interpretation reveals the relational and contextual nature of being-in-the-world. It is this focus of hermeneutic phenomenology, on disclosing the relational and contextual nature of being-in-the-world through interpretation, which makes it useful for revealing the nature of everyday experience in nursing practice.

Such ostensibly abstract theoretical considerations may seem far removed from the world of nursing practice. Nonetheless, as it will become apparent, they have critical implications for how the study was pursued. They will be seen to lead to an approach which focuses on how the nurses practise in their everyday world of work, and which interprets their practices and experiences in such a way that they are not separated from either the nurses or their ongoing practice situation.

THE STUDY

The goal of the study is to examine the nature of everyday experience in nursing practice and its contribution to the development of clinical expertise. The intention was to come to an understanding of everyday experience among nurses who were considered to be excellent practitioners. To this end, I observed ten experienced surgical nurses in practice and interviewed them about their experiences. The field notes and interview transcripts provided the 'material', the text for interpretation. The process and spirit of this research has much in common with the hermeneutic circle (Heidegger 1962), in which we understand something only in relation to its parts, and as we gain knowledge of a part, our understanding of the whole changes. This understanding of research presumes an openness: it is an approach which could be described as a dialogue, hearing what the nurses are saying and doing and, in turn, responding to the questions that are posed by their practice and experience (Gadamer 1979). Thus, the plan of the study was not pre-set, but rather, evolved as a new sense of the parts and the whole emerged.

The study has not been formless, however. Throughout, I have kept two principles at the forefront. First, my attention has been focused on the nurse-in-practice, not on the nurse removed from a context, nor on the context without the nurse. Second, I have endeavoured to 'keep close' to experience, to continually ask while in the field and during interpretation, "What does this mean about experience?". These two principles have been touchstones throughout the study. I considered them to be much like the central agenda when planning a conference or programme. I have found that when the central agenda is clear, then there is room to be spontaneous and "go with the flow". If the agenda is not focused, if the 'ends-in-view' (Dewey 1925) are unclear, or if the important issues have not been thoroughly thought through, then you are too preoccupied with them to be able to appreciate the possibilities for spontaneous action. You are also too preoccupied to know when you could or should deviate from the plan, or abandon it altogether.

The focus of my attention throughout this study has been the nurse in the context of her experience, specifically her nursing practices. The goal of the research has not been to get at the essences of lived experience from the perspective of the nurses as in other phenomenological research (cf. Oiler 1982, Forrest 1989), nor has it been to determine the operative social processes as in other interpretative research (cf. Melia 1987, Chenitz and Swanson 1984). Rather, in this research I have sought to illuminate themes in nursing experience, to discover the relational issues between the nurse and her context and to achieve understanding.

As mentioned earlier, the skills and inclinations of the researcher, though important in all types of research (cf. Polanyi [1958]1962), are of particular importance in interpretative research. Clark (1989, 56-59) provides a useful discussion of the expertise needed by the interpretative researcher who is attempting to understand the nature of knowing in practice. He rightly suggests that in addition to knowledge of the theoretical area and the tools and techniques of research in the particular discipline, the researcher needs to be accomplished in skills which enable her to comprehend and make sense of taken-for-granted practices and common sense knowledge. As Giddens (1976, 155) puts it, "The social scientist of necessity draws upon the same sorts of skills as those whose conduct he seeks to analyse in order to describe it". First amongst the skills is language. It is not enough to understand the words, it is necessary to grasp such

things as jokes, allusions and the different meanings of words in different contexts when used by different speakers. The second area is skill in comprehending the meaning of non-verbal behaviour. Although Clark puts this behind language in importance, I would suggest that skills in understanding everyday language and non-verbal behaviour are equally important and inseparable. The third area is knowledge of the disciplines, conventions, ideologies and practices of the particular field, in this case, nursing. The fourth area concerns the relevant contextual knowledge, the knowledge of nursing practice in the wards under study. The fifth concerns skills of the research method: in this study, observation and reflexive interviewing techniques and hermeneutic interpretation skills. Sixth and last, are the attributes of age, gender and ethnicity. Each of these six areas will be addressed in the subsequent discussion about how the study was carried out. I hope that by describing my reasons and actions, my mistakes, as well as my successes will be open to view.

One of the perennial concerns of researchers in the qualitative mode is the issue of rigour. According to Robinson and Thorne (1988), "Careful reflection, meticulous reporting and vigorous debate must be hallmarks of the process [qualitative researchers] use...." Guba and Lincoln (1981) suggest that researchers spell out their "decision trail" so that others may audit the process. At the risk of being overly detailed, I will attempt in this discussion to explain the decisions which I took and indicate how they influenced the course of the study. The first of these concerns the specific research questions.

Guiding Questions

At the outset of the study, several specific questions were created to serve as guides for the field work. I began to negotiate access to nurses in the clinical area with the question, How do nurses learn through experience in clinical practice? There were four sub-questions:

- What experiences in practice are significant for nurses with regard to learning practical knowledge?
- What meanings are embedded in these experiences?
- What features in the context of the experiences influence nurses' subsequent practice?

- What is the nature of learning in these experiences?

As the field work began new understandings were gained and these specific questions quickly became too limiting as I found the notion of experience to be less clear-cut than I had taken it to be. Rather than replacing these questions with other specific questions, they were kept in abeyance. As the research progressed, I kept the two principles: the nurse-in-context and keeping close to experience, at the forefront of my mind and continued to explore how meaning, learning and knowledge were revealed in the nurses' experiences and practices.

As excellent, experienced nurses were selected to participate in the study, I felt that I could not simply focus generally on learning through experience, so the general question was reorientated early in the period of fieldwork to: "How do nurses develop expertise in clinical nursing practice?" Some time later, when I was well into the analysis, I was beginning to understand that, in addition to everyday experience, I was looking at nursing practices and the process of practising expertly. Everyday experiences provided a window to nursing practices, and by examining how nurses experience practice on a moment-by-moment, day-by-day basis, another window was opened, this one into the process of practice. A question, "How do nurses practise expertly?", was added. It must be said that although the questions served to focus aspects of the study, the overall goal remained intact: namely, to explore the nature of everyday experience and its contribution to the development of clinical expertise.

THE NURSES AND THEIR SETTING

The study was undertaken in a large Scottish city. Following contact with the Health Board's Chief Area Nursing Officer (see Appendix 1), an initial exploratory meeting was held with the Area Nursing Officer responsible for research. She contacted the Directors of Nursing Service of two acute care hospitals and secured permission for me to contact them (see Appendix 2). Both hospitals are multi-specialty, university-affiliated hospitals, involved in research and the education of medical, nursing and paramedical personnel. One hospital is large (over 900 beds); the other is smaller (over 400 beds).

Initially, I asked for "qualified nurses who are acknowledged to be experts in surgical nursing". I specifically wished to study nurses in adult "general" surgical

nursing units for the following reasons: *One:* I am most familiar with surgical nursing of adult patients. My clinical experience is not extensive. Most recently, while working in nursing administration, I maintained a connection with a surgical ward, occasionally participating in patient care and assisting with the development of primary nursing. *Two:* Nurses are often expected to gain "basic experience" in general surgery. Nurses working there are not considered to be specialists; there are no post basic courses offered in general surgical nursing. For the most part, nurses in these areas develop their particular nursing knowledge through self study and practical experience. *Three:* For the purposes of observation, the "pace" of these wards is often more rapid the other area with which I am familiar, Geriatrics. More opportunities are afforded to observe nurses in a broader range of practice.

Prior to my discussions with the Directors of Nursing Service I had not determined what would count as "general" surgical nursing units, except to exclude intensive therapy units.

At my initial meetings with them, the Directors of Nursing Service expressed interest in the study and a willingness to participate. We discussed the term "expert", noting how unfamiliar it is in the Scottish nursing context and agreed that it would be more comfortable to speak of "excellent, experienced" nurses, a term I used for the remainder of the study.

The Nurses

Nurses were selected by the Directors of Nursing Services using the following criteria for selection:

- Employed in nursing clinical practice for at least five years.
- Currently engaged in direct patient care in a surgical nursing setting.
- Identified by colleagues as highly skilled clinical practice nurses.
- Employed full-time in nursing.
- Registered general nurses.

These criteria were used by Benner (1984) and others (Olsen 1985, Crabtree and Jorgenson 1986, Benner and Tanner 1987) to identify expert nurses. In Benner's (1984) study, the expert nurses were selected by staff development directors in consultation with head nurses and peers. Crabtree and Jorgenson (1986) selected a random sample from eligible nurses identified through responses to a mailed questionnaire. Recently, Hyslop (1987) expressed concern regarding the use of peer nomination as a means of selecting expert nurses in Scotland. In his study of expert decision-making on pressure sores, he selected expert nurses through self report and an assessment test, noting that nurses do not work together enough to allow them to nominate their peers as experts.

In the initial discussions with the Directors of Nursing Services, I stressed that numbers were unimportant; my main concerns were that the nurses were excellent, experienced surgical nurses and that they would be willing to participate in this in-depth study. Both Directors said that nurses who met the criteria immediately came to mind. Following the meeting, in consultation with their senior nursing officers for the surgical areas, the Directors selected nurses for participation in the study. Seven nurses were identified at the larger hospital, and three at the other. One Director said that she and her colleague had separately identified nurses and had found that in six of seven cases they were the same. Originally I wanted to study fifteen nurses, but found that there was more than ample material generated in the study of ten.

The nurses selected were eight ward sisters and two staff nurses. They are referred to in the study by pseudonyms, which are listed in Appendix 3. Nine of the nurses work full-time; one of the staff nurses, though part-time, has worked for many years on one ward and conducts a weekly outpatient clinic. The second staff nurse acted up during part of the study, and was promoted to ward sister following the period of field work. Because both of the staff nurses had responsibilities which are normally those of a ward sister, I have called all of the nurses "Ward Sisters" for the purposes of the study. Where the nurse's role as a staff nurse was pertinent to the analysis, it has been mentioned.

All of the Ward Sisters have extensive experiences in nursing. As of the spring of 1988, at the completion of the field work, the Sisters had been qualified nurses from between six and 33 years. Five Sisters had between six and twelve years of experience, the other five Sisters had between 24 and 33 years of experience. Most

of their experience had been in surgical nursing. The Sisters had been their current post between 2.5 and 12 years, the mean being 6.5 years. The summary of their qualifications provided in Appendix 3 shows the Sisters to be experienced, clinically qualified nurses.

In these hospitals, as in many others on both sides of the Atlantic, it is not unusual for certain nurses to be "volunteered", or encouraged to participate in research studies or developmental projects. Often these nurses are amongst the informal leaders in the organization who can be counted on to test system changes fairly or to lead organizational developments. It is notable that during the period of field work and afterward, sisters in the study were involved in, among other projects: testing a new medication administration system, a work analysis programme, and leading the development of nursing standards. Several of the wards are often used by the Colleges of Nursing for students or staff who need extra assessment or developmental work.

Not all of the Sisters were enthusiastic volunteers. Two in particular were reluctant to participate. I gave them the opportunity to decline, but admittedly, given the process of selection, it was difficult for them to opt out of the study.¹ Therefore, with all of the Sisters, but with them in particular, I made every effort to suit the field work schedule and my way of working to their needs. On a number of previous occasions, I had to create a cooperative work situation with people who were initially reluctant or actually hostile. Particularly with some of the Sisters, I drew on all of this developmental experience and stretched my skills. I was particularly sensitive to being in an unfamiliar cultural and social situation. My success can perhaps be judged by the fact that all of the Sisters participated fully and openly throughout the duration of the study; none of them were stinting in their involvement.

¹ See Appendix 4 for the letter to the Sisters confirming my involvement and their participation. I used it in lieu of a consent form, as a consent form was not required by the Health Board or either hospital. This was sent to each Sister at least one week before beginning participant observation with her.

Their Wards

Although nurses on general surgical wards were requested, it is perhaps instructive of the state of surgical nursing that only two of the ten wards are actually general surgical wards. The wards in the study were the following:

- ear, nose and throat
- general surgery
- gynaecology
- orthopaedic trauma
- thoracic surgery
- urology
- vascular surgery

Appendix 5 contains details about the numbers of beds, the sex of patients and architecture of the wards.

FIELD WORK

Access to the two hospitals was negotiated in June and July, 1987. The field work began in August, 1987 and continued until June, 1988. Field work consisted of two periods of observation and three interviews with each Sister. In addition, a group interview was held. From August to November 1987, I "shadowed" each Sister for five days and conducted the first interview shortly thereafter. Between December 1987 and February 1988, I interviewed each Sister a second time. Between March and June 1988, I shadowed the Sisters again for two days and conducted the third interview in the afternoon of the third day. The group interview was held with seven Sisters in mid-June, 1988.

Participant Observation: Shadowing the Sisters

It was originally intended that the interviews would provide the main source of material for analysis and the period of participant observation would provide me

with a sense of the context, and therefore enable a better interpretation of the interview material. During the first day of observation it became apparent to me that there were many practices which were effective because of the Sisters' particular movements, her use of personal space, timing, pacing and voice intonations. I was picking up "the kinesic dimension of professional performance" (Dingwall 1976), the Sister's comportment. I realized at the time that this dimension was critical to her effectiveness in practice yet would not be talked about in the interview situation. Thus, I approached the participant observation in such a way that I could gain the maximum amount in the limited time I had with each Sister.

The literature on participant observation stresses the need to spend time immersing oneself in the situation (cf. Hammersley and Atkinson 1983) in order to understand the "matrix of meanings" of those studied (Emerson 1987). As a nurse, I already had access to many of the meanings and much of the professional knowledge. This was critical as I attempted to follow what each Sister was doing in the course of her clinical practice. On the down side, my nursing experience has taken place entirely in Canada. I was unfamiliar with the Scottish nursing practice context.

Common problems for the participant observer, such as when to be in the field, where to stand and what to observe, were somewhat simplified for me. Quite literally, I shadowed the Sisters throughout the course of their workday for five consecutive shifts in the first phase of the field work, and two consecutive shifts in the the second. The period of five days was chosen to give me a chance to be with each Sister within a three month period. There were considerable scheduling difficulties; any longer than five days would have been impossible to implement within that time. Although the Sisters often work for longer periods, five days allowed me to capture a sense of their experience of a working week. For two Sisters, it was impossible to schedule five days, so I was with them for four days apiece. I was with each Sister for their entire shift (which often lasted 9 hours); the part-time Sister worked 4 hours each day. Early and late shifts, weekdays and weekends were included. In the first phase of the field work, I observed the Sisters for a total of 360 hours.

In the third phase of the field work, my intent was to observe the Sister for a sufficient amount of time to become familiar again with her practice and provide

the basis for discussion. I was with all but one of the Sisters for two consecutive shifts, for a total observation time of 128 hours. The interview was held in the afternoon of the second shift. As one of the Sisters was "acting up" as the nursing officer at the time, I did not observe her in practice. I interviewed her however, about practices which I had previously observed.

In the hospital wards, I wore a blue skirt, white shirt, nurses' shoes and a white laboratory coat with a badge identifying me as "Martha MacLeod RN, Nursing Research Student, University of Edinburgh". Each Sister had a different way of introducing me on the ward. I was usually introduced to the doctors and nursing staff as a "Nursing researcher who is studying me and how I work. She will be with us for the week." All of the Sisters were aware that I am registered to practice as a general nurse in the United Kingdom. Some mentioned the fact in their introductions to staff. To the longer term patients I was introduced as "Martha MacLeod, a Canadian nurse who is doing research"; I was often not introduced to patients who were on the ward for a short period of time.

The Sisters included me in virtually all their activities. I was not included in two "difficult" student assessments, and on one occasion at medical rounds, the consultant and the Sister went to look at a woman's anal cyst, leaving the registrars, residents and me in the hallway. On all other occasions, including giving relatives news of a patient's death, meeting with a staff nurse for the first time and being with the Sister "behind the curtains", I was there. The Sisters did not attend administrative meetings while I was with them, so I did not observe that aspect of their work. My participation in care was limited, but I helped to lift and turn patients, make beds, tidy work areas and answer the telephone. When shadowing one of the staff nurses, the patient assignment was given with an acknowledgement that I would be available to help with the bathing, lifting and turning. At all times, my participation in care was at the Sister's request and happened with her.

When I shadowed the Sisters, I stood where I could see their faces and the patients' faces and hear their conversations. I was part of the group receiving the ward reports, and at doctors' rounds stood where I could see and hear the Sisters' interactions. I wear a hearing aid that enables me to hear "normally", however I am particularly attentive to faces, and I made sure that I stood where that was

possible. During the field work, my main difficulty was catching what the consultants said during rounds.

My attention during participant observation was focused on a Sister's practices: what she was attending to, what she was doing and how what she was doing fit with and formed the situation. I watched and listened for the responses of others to the Sister's actions. I continually had to try to make sense of what was going on. Just as Atkinson (1984) found he learned about medicine while studying medical students, I found that I was learning about each of the clinical specialties so I could understand what the Sisters were doing. The first day was particularly difficult as I had to become familiar with the new pace, people, concerns and language of the ward. After the first day, in which I mostly listened and watched, I often asked the Sisters' what they saw, or what they were thinking. They were used to having students around and frequently, spontaneously explained what they were doing, why they were doing it and what they were going to do next. This was invaluable.

My presence was, to all accounts, well accepted. I seemed to be perceived by patients and staff, not so much as an intruder, but more as "an extension" (Kratz 1975) of the Sisters for the time I was with them. The Sisters said that they found me comfortable to have around. They were surprised at this, as most had not looked forward to being so closely observed. My age and previous administrative position did not seem to negatively influence the field work. I am older than half of the Sisters. They related to me as a Canadian student, a researcher and a nurse. While I recognize the limitations on my insights into the Sisters' world of practice afforded by such a short period of participant observation, their openness enabled me to get the most out of that time.

I took notes in a small notebook throughout the shift. As many others are taking notes in handover reports, my note-taking was not obtrusive then or during rounds. I often jotted down reminders and phrases while the Sister was on the telephone, writing in the kardex, or doing some paperwork herself. One Sister said that she often forgot I was there except when my pen would come out. After that, I tried to make my note-taking even more unobtrusive. On the other hand, two Sisters asked me to take a couple of reminder notes for them, and another used the times I had written down to confirm her understanding of a situation. Following each day of participant observation, I created field notes on the

computer out of the jottings. This was difficult to maintain with the work schedule, but usually they were completed within two days, and in all cases the field notes for my time with one Sister were completed before shadowing the next.

The Interviews

Each Sister was interviewed three times, with three months between each interview. The interviews were held in the Sister's room or another office on the ward, during their regular working hours. Each interview lasted between 35 minutes and 2 hours; the average was 80 minutes. The later interviews, without exception, lasted longer than the first interviews. The interviews were tape recorded and the recordings transcribed verbatim.

Two practice interviews were held before the beginning of the field work with two undergraduate nursing students. The interview format for the first interview was used. These interviews were useful for allowing me to become used to the tape recorder and for becoming aware of some abruptness in my interviewing technique, which I subsequently modified.

The interviews could be characterized as reflexive interviews (Hammersley and Atkinson 1983). There was an underlying structure and agenda which I determined, but the direction in which the interview developed was influenced by, amongst other things, the experiences related by the Sisters, our comfort with each other and the Sister's current work concerns. I approached each interview with a goal in mind, an opening question, areas to discuss and probes (See Appendix 6). I followed Bogdan and Taylor's (1975, 108) maxim that what is ultimately important in a qualitative interview, is a clear frame of reference. The interviews were much like those described by Tough (1982): intensive, probing, medium paced (almost leisurely at times), and in-depth.

In the first interview, the Sisters were asked to describe experiences in their practice, for example: a situation in which they made a difference to a patient, a situation that went unusually well or one that was very ordinary and typical. The questions and probes were taken from Benner (1984). Unlike Benner's (1984) or Crabtree and Jorgenson's (1986) studies, I did not provide an outline of the kind of description I was interested in prior to the interviews. Only one of the Sisters

asked me before the interview what kinds of questions I would be asking, and when I told her, came prepared with some "stories" [her word] to tell me. At the beginning of the interview, the Sisters did not find it easy to tell me about their own experiences, but once they had related one, they readily told me about other experiences with memorable patients. Two nurses in particular talked about what they normally did in situations; I found myself continually asking them for specific examples, which they willingly provided. The form of the experiences related in the interviews are discussed in relation to the nature of experience in Chapter 5.

As many of the experiences and memorable patients discussed in the first interview pertained to situations early in the Sisters' careers, my goal for the second interview was to hear about more recent experiences, and for the Sisters to make links, when they could, between the experiences related and earlier or subsequent experiences. In this interview, the Sisters gave me specifics without my having to probe; they no longer asked if they were "going on" or "off on a tangent"; two or three told me about situations of which they had thought at the time, "Martha would be interested in this". These situations were one in which a simple nursing action had made a difference to a patient.

The first and second interviews elicited few very recent experiences and there were considerable areas of their practice which they did not talk about at all. Therefore, I began the third interview by asking the Sisters to tell me about the last two days. I then moved on to commenting on two or three of their practices which I had observed, and asked them if they remembered when they did not do them as well. The concentration in this interview was more on their learning and influences on that learning. In this interview, I also asked about their education and work experience (see Appendices 3 and 6).

The interviews took place at the Sisters' convenience, usually in their room on the ward. We were seldom interrupted. The interviews were recorded by a small hand-held tape recorder placed between us. None of the Sisters particularly liked being recorded and one person strongly voiced her concerns, but nevertheless agreed to be taped. This same person commented at the beginning of the third interview how she felt crowded by where I had sat in the second interview, so I moved to where it was comfortable for her. At the same time as expressing her

dislike of interviews, she commented on how easy it was for her to have me shadow her.

To conclude the field work, I held a one and one half hour group interview with seven of the ten Sisters, exploring themes I found amongst them all (see Appendix 6 for the interview themes). One Sister came in from holidays for the interview; staffing difficulties prevented two from attending and one was out of the country. They commented later on how nice it was to get together.

Following each interview, I added my comments about the interview to the tape; they were transcribed along with the interviews. All of the interviews were transcribed verbatim in the first instance by a research assistant. I listened to all the tapes, checked the transcription and ensured all were complete. Often discussed amongst researchers, but seldom included in research reports is the question about the necessity for a complete transcription, including the normal grunts, repetitions and other flotsam of normal speech. These were included in the transcriptions because they are a normal part of language, and can point towards the emotional content, the ease of expression and the character of the experience being recounted. However, even with a complete transcription of an oral conversation, the language is, of necessity, transformed. The written artifact can never capture all of the vividness, the pacing and the non-verbal aspects of the conversation. In the chapters which follow the interviews have been edited for the sake of clarity (see Chapter 5 and Appendices 7 and 8 for an explanation of editing marks and an example). In making these editorial changes the intention has been to achieve "fidelity to the participants' meaning" (Weber 1986). The changes have been made with the encouragement of the Sisters. Indeed, upon reading the first drafts of the interpretation, they requested changes in their dialect or use of colloquialisms to make them "sound more professional". In most instances, these changes were made with the recognition that "public talk" is often more coherently presented than the "private talk" which is captured in tape recordings of conversations, albeit interview conversations (Tilley pers. com. 1990).

A HERMENEUTIC INTERPRETATION

In this study, the interview transcripts and field notes were treated as text, or text analogues and a hermeneutic interpretation carried out with them.

Hermeneutics derives from a reference to Hermes, the Greek messenger god, who had to understand and interpret a multiplicity of messages, languages and meanings of the various gods, so that he could translate and convey their meaning to mortals. Hermeneutics is an "attempt to make clear, to make sense of an object of study" (Taylor 1971). Originally, hermeneutic interpretations were only undertaken on written texts but Ricoeur (1979) successfully makes the case for the applicability of hermeneutic interpretation to both action and speech. Ricoeur argues that language in discourse, both written and spoken, can be fixed and thus become the subject of hermeneutic interpretation. This is no less so for meaningful action which can be described. In the inscription of discourse and action into texts and text analogues, they become distanced from the writer, speaker or actor. "The author's intention and the meaning of the text cease to coincide" (Ricoeur 1979). They are thus placed in the intersubjective realm. The world and situation of the discourse are then able to be addressed.

The process of hermeneutic interpretation as proposed here is underpinned by the following principles:

- *The researcher enters into dialogue with the text (Gadamer 1975).*

The interview, a work of discourse, tells a story about a particular topic or issue (Honey 1987). In this case, the story is about nursing experience. The statements within the story, both those of the Sisters and mine, could be considered responses to questions. As Gadamer (1981, 106) says, to get hold of the statement of the text is to get hold of the question to which the statement is an answer. To put it another way,

Interpretation is a response to questions put not solely by the interpreting subject to an object, the text.... It is a response to questions raised by the subject matter of the text. (Llewelyn 1985, 115)

Thus, the interpreter needs to attend to what the text is saying, and to the question to which it is responding. "A good interpreter must be a good listener" (Llewelyn 1985, 111).

Unlike other forms of phenomenology (cf. Giorgi 1975, Giorgi 1985, Omery 1983) the researcher in hermeneutic phenomenology does not 'bracket' his or her

presuppositions, reduce the phenomena and stand outside the text. Rather than being disengaged, the researcher is reflective but engaged with the situation (Packer 1985). The process of interpretation stemming from engagement with the situation may be characterized by Gadamer's notion of a "fusion of horizons" (Gadamer 1975). Our horizon, according to Gadamer, is our range of vision which includes everything that can be seen from a particular vantage point. The horizon of the present is constituted, as mentioned in a previous section, by our background, or pre-understandings. As such, they are impossible to see beyond. However, through engagement and dialogue, the horizons of the present can be transcended. It could be said that our horizon is something that moves with us as we encounter the world. Gadamer makes the point that interpretation is a process imbued with time.

In fact the horizon of the present is being continually formed, in that we have continually to test all our prejudices. An important part of this testing is the encounter with the past and the understanding of the tradition from which we come. Hence the horizon of the present cannot be formed without the past. There is no more an isolated horizon of the present than there are historical horizons. Understanding, rather, is always the fusion of these horizons which we imagine to exist by themselves. (Gadamer 1975, 273)

The researcher as interpreter comes into the act of interpretation with a set of personal preconceptions or prejudices and a theoretical lens (Kuhn 1977). Through the process of interpretation, these become more clearly articulated in relation to the text. Rather than trying to get free of "researcher bias", the researcher recognizes her influence on the interpretation while attempting to fully hear the voice of the text.

Thus it can be argued that the meaning of an action or text (or text analogue) does not rest only in the writer, actor or speaker, nor in the interpreter alone, but is constituted in both.

- *The process is not linear. It is characterized by the hermeneutic circle.*

Central to the notion of the hermeneutic circle is the interplay of the parts and the whole. To understand the whole, the parts are understood, part by part, so that a

progressively more complete awareness of the whole is grasped. The comprehension of each part, however, is enriched by the understanding of the overall whole. In this way, the hermeneutic circle gives a direction for the method of interpretation to be used by the researcher. Understanding is as a whole and not merely as the addition of discrete elements. The hermeneutic circle has implications for the form of analysis.

- *The process of analysis is systematic, a "dialectic of guessing and validation" (Ricoeur 1979).*

Throughout the process of interpretation, the horizon of understanding is tested and reformed through the process of dialogue with the text. As a part of this process, the researcher is constantly making comparisons amongst instances in the text (cf. Glaser and Strauss 1967, Glaser 1978) and amongst the evolving themes and their interplay with the text.

- *The goal is not to understand the text, but to understand something in front of it - the human pro-ject (Heidegger 1962, Rabinow and Sullivan 1979).*

The interpretation which is sought is a new creation, a synthesis of the horizons of both the text and the interpreter. The interpretation does not lie underneath, nor behind the text, but rather in-between the text and the interpreter. The interpretation sought in this study is not the Sisters' interpretation of their own situation, nor is it merely my interpretation. Instead, I am aiming at an interpretation which brings to light what the Sisters already understand about their experience and practices, but bringing them to light in a new way, in a new interpretation, one beyond their own.

- *Universals or theories are not identified through this process, rather human context and world are explicated (Rabinow and Sullivan 1979).*

The interpretation discloses the complexities and interrelatedness of meanings in context. Within the perspective of hermeneutic phenomenology one can never be clear of the context, if for no other reason than that language embodies the cultural world within which the researcher and research participants live (c.f. Taylor 1971). Thus, context-free theories provide too skeletal a view of the Sisters' experience and practices.

The second characteristic of the hermeneutic circle also figures here. Within hermeneutic interpretation, there is never a final or absolute interpretation.

We cannot escape an ultimate appeal to a common understanding of the expressions, of the "language" involved ... What we are trying to establish is a certain reading of text or expressions, and what we appeal to as our grounds for this reading can only be other readings. (Taylor 1971, 6)

It is not an arbitrary interpretation which is sought, but one which best makes sense in this place and time. As Strong (1979, 250) states, "The best we can hope for in this world, even if we study practical reasoning, is a plausible story." I would argue that the interpretation in this study must make theoretical sense (Silverman 1989), but also must be recognizable by the Sisters and others who are familiar with situations such as theirs.

Interpreting the Interview Transcripts and Field Notes

The field notes were written and the interviews transcribed using a Macintosh SE computer with a hard disk. The material for all of the nurses totalled 2500 pages of text, about 250 pages per Sister. A major challenge was to find a way to keep a sense of the whole, whilst analysing parts. In contrast to Knafl and Webster (1988), who suggest that data management activities are undertaken merely to prepare data for analysis, I would argue that the management of data in itself is part of the analytical and interpretative process. This is particularly so when the aim is not to reduce the data to pieces and subsequently reassemble them, but rather to come to an ever richer understanding of the parts and the whole.

The interview transcripts and field notes were assembled for each Sister. I worked with a paper copy with a wide right hand margin. My original intention was to begin by reading the material as a whole for all the Sisters as Diekelmann, Allen and Tanner (1989) suggest. This proved to be too daunting a task, so I decided to work with the material for one Sister at a time. In the first instance, I read the material as a whole without taking notes. I then took each day of field notes and each interview at a time. I began with the field notes, in order to get the context of work and took the interviews in the order: 3, 1, 2.

Keeping the two principles: the nurse-in-context and keeping close to experience, in mind, I asked these questions as I was going through the text:

- What is going on here?
- What is the nature of experience?
- What is knowing in this situation and how does it show up?
- What learning is here? How does it happen?
- What is the nature of the situation?
- What is the temporal nature of the experience?
- What does this particular situation/aspects of the situation link to - and how do they link?

I was unable to identify a firm "unit of analysis" or "meaning unit" (Giorgi 1985). Benner (1984), Diekelmann (1989) and others used the paradigm case as the unit of analysis, however the experiences in the interviews in this study did not all fall into the form of paradigm cases and exemplars. Brykczynski's (1985) study used discrete nurse-patient encounters as units of analysis, in addition to paradigm cases. However, the field notes in this study took a different form, following the variety, complexity and discontinuity of the Sisters' work. Trying to identify a unit of analysis was useful, however, because I was pushed into considering the form of experiences. When an "experience" could not be readily identified, I asked myself, What is this then? In addition to considering the content of the interviews, I examined the turns in the conversations - where they came from, what seemed to be happening and where the turn led. Reading the field notes, I asked: What makes up an experience? Whose experience is it - mine or the Sisters'? I explored the character of experience over a period of days in the field notes, between interviews and between field notes and interviews.

During this process, I highlighted what stood out, wrote brief margin notes and then went through the notes and text again, making further notes on separate sheets under four headings: Experience, Knowledge, Learning and Flavour, linking them to instances in the text. After completing these notes for all of the material for one Sister, I read them through and identified ideas or questions, writing them on file cards. These ideas were much like overlapping, amorphous

categories with a quote attached, and/or thoughts which they provoked. I considered them to be worth exploring further. For example, cards were created with the titles, "little things, helping, doctor-nurse relationship, safety net, wounds, comfort, staffing, noticing". For each Sister, I created a new set of cards and labels. I did not seek to fit the ideas into discrete categories, but during this process, I was identifying where the ideas/issues (e.g., authority) showed up and where they did not, and how they were different between Sisters and among experiences. Throughout this process, there was a continual interplay between the parts and whole, within an interview or day of field notes, and between the parts and whole of material for each Sister.

For each Sister, I made a card "Flavour" with quotes and situations which particularly stood out, and another card, "Knowledge" in which I cited examples in relation to Benner's (1984) domains. As well, I did not attempt to bring out all of the possibilities in the text: the material is so rich I would still be analysing it. Instead, I worked with each Sister's material until I thought I knew it well, and had grasped as much as possible in it. This process took three 40-hour weeks for the first Sister's material, two weeks for the second, four for the third, and between one and two weeks for each of the other Sisters' material.

As part of this process, colleagues read excerpts from the text and we compared analyses. It was particularly useful on two counts: for helping me to be more clear about my prejudices, and for looking at the text from more than one angle.

The next stage was to review the cards and notes which I had made for myself. (These were much like Glaser's (1978) theoretical memos.) I made piles of similar cards and looked for patterns and areas of dissimilarity within and among them. I also looked at how they fitted with Experience, Knowledge and Learning. I was trying to get a sense of the whole for all of the nurses and how the parts fit in. At this stage, I was forming loose themes (e.g. knowing the patient). I discussed these with colleagues and with two of the Sisters who said that they made sense to them.

I began writing at this point, creating a description of each Sisters' practice. This description highlighted a lack of pattern in the material, and the fact that I had not adequately grasped the whole. I then spent three weeks in front of a blackboard with the material, searching for patterns. A number of themes emerged, such as:

nursing practice - experience with individuals; nursing practice - experience with groups; the process of practising; the process of learning through experience. These themes and central links amongst the themes were further developed through writing several drafts of the chapters which follow.

A great deal of the interpretation and understanding has occurred through writing and rewriting. As Van Manen (1984, 68) says, "To write phenomenologically is the untiring effort to author a sensitive grasp of being itself...." I have found that I have needed to work at developing a style of writing which conveys the nature of everyday experience.

To write, to work at style, is to exercise an interpretive tact, which in the sense of style produces the thinking/writing body of text. ... But we should not confuse style with mere technique or method; rather, style shows and reflects what the author is capable of seeing and showing in the way that he or she is oriented to the world and to language. (Van Manen 1989, 242)

The interpretation which is presented in this thesis has developed and changed through the various drafts of this study.

The Sisters were involved at several points in the development of the interpretation. In June, 1989, one year after I had left the field, I met with six of the Sisters to present a paper to them, "'He's Better in Himself': Nurses Knowledge of the Patient Recovering from Surgery". Their response was warm. One Sister said, "What you say makes what we do sound important!" She paused and continued, "Of course it is, but I mean, it's just what we do." Another Sister, who had read the first draft of one chapter said about it, "It is easy to read and riveting. The only down side is that the not so nice aspects of our practice aren't shown." Over the next five months all of the Sisters read all of the analysis chapters in first draft. Overall, they agreed with the interpretations and made specific corrections, such as the names of medications and the sequence of a procedure. One Sister, said that she had taken the section, "Making the Ward Work", to her husband and said to him, "Read this. This is what I do!" Another Sister wrote: "Many things which you have mentioned in your paper have helped me understand the situation more...."

Late in 1989, I presented a paper, "Attuned to Experience: How Nurses Practise Expertly", to the Sisters before giving it elsewhere. They pointed out some unclear wording but supported the interpretation. A spirited discussion about the importance of caring and the nature of expertise followed.

ISSUES OF ETHICS AND RIGOUR

Confidentiality has been perhaps the most difficult ethical issue in this research. At the outset, I promised confidentiality to the Sisters. The names used throughout are pseudonyms, however, it is quite possible that within their milieu they will be able to be identified. I raised this issue of confidentiality with them as soon as it became apparent to me that I could not avoid the potential of disclosure if the context were to remain intact. We discussed this at length and the Sisters have agreed with the approach I have taken. As one wrote after reading the draft chapters, "It is unfortunate that the Sisters' concerned can be identified by their specialties but I cannot see how you can avoid this as it is necessary to the context of the paper." The move to name all of the nurses, including the two staff nurses, "Sister" may lessen the potential of their identification. At no point have the Sisters asked that a situation be omitted. Only minor modifications have been requested. For example, one Sister requested that reference to a specialty be removed from an example in which she was talking about previous experiences as she felt another person might be identifiable.

The Sisters have been consistently supportive of my creating an open and balanced interpretation of their practice and experience. The apparent lack of "negative" instances of practice in the following chapters is not an oversight. It occurs for two reasons. Although I was not out to evaluate practice, interpreting the quality of situations is an unavoidable part of understanding them. You see the effect of actions as well as the actions themselves. The examples provided in the following chapters are representative of the Sisters' practice. They described many days that I was with them, typical days. I did not observe instances of "poor" practice. That is not to say that the Sisters did not think they could have handled situations better. There were also instances in which I could have suggested an alternate approach, but their approaches made sense in the situation. The Sister who made the comment about the lack of negative instances said she was thinking of a time in which she did not handle well the timing of attending to relatives of a patient who died. My understanding of the situation was tempered

by the realization of the tremendous number of other details she was attending to at the same time in an extraordinarily difficult situation. I was marvelling that she was timing it as well as she was. The second reason for a "positive" description is the perspective offered by hermeneutic phenomenology. The approach leads to focusing on what is there in language and practices, not on what is lacking. It does not provide a deficit view (Benner 1985).

Throughout this discussion, I have attempted to highlight the points of decision, so readers may audit them. Although I would argue that reliability in the usual sense is not possible because of the contextual nature of the research and the individuality of the researcher, there is a need to address the reliability of the interpretation (Silverman 1989). The openness and details in this chapter are an attempt to establish the trustworthiness of my interpretation. A credible, robust interpretation has been sought through such means as: creating a rich source of material for interpretation from participant observation, multiple interviews with the same individuals and a group interview; undertaking the interpretation in multiple stages; testing out the interpretation with the participants and colleagues; undertaking a style of research which is within the capacity and skills of the researcher. The ensuing chapters reveal the fruits of these efforts.

CHAPTER 5

EXPERIENCE AS MOVEMENT

In the course of the interviews, the Sisters described in some detail their experiences in nursing and of people they had nursed. As I shadowed them in practice, they would sometimes comment on what they were doing, either spontaneously or in response to a question from me or a student. Perhaps what is most striking to me in their accounts is how elusive and fluid experience seems to be and how much of their everyday practice is taken for granted and is therefore missing from the accounts. From this, it appears that the notion of experience is not as straightforward as it first seems and is often taken to be in the literature. The temporal nature of experience, its meaningfulness and its personal yet contextual nature, all contribute to its complexity and elusiveness. This chapter concerns the problematic nature of experience and how experience manifests itself in the accounts and practices of the Sisters.

THE PROBLEM WITH EXPERIENCE

Time and Meaning in Experience

The experiential learning models (Lewin 1952, Revans 1980, Kolb 1984, Boud, Keogh and Walker 1985, Jarvis 1987a) perhaps show most clearly that when experience is taken to be an atemporal event it can be isolated, described and reflected upon. On this analysis, experience "consists of the total response of a person to a situation or event: what he or she thinks, feels, does and concludes at the time and immediately thereafter" (Boud, Keogh and Walker 1985, 18). In these models experiences are presented as but one discrete stage of a serial, circular process. Although the specifics of the models differ considerably, their basic stages are similar to those first outlined by Lewin (1952) and picked up most directly by Kolb (1984).

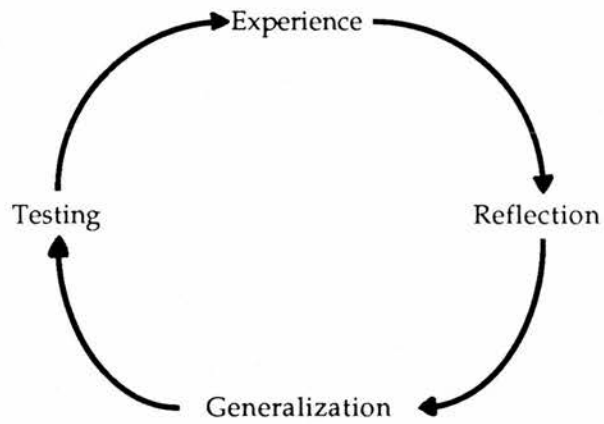


Figure 2. Experiential Learning Process

The experiential learning theorists take the view that experiences do not have value in and of themselves, but are a source of concepts or material for reflection. Experiences are essentially atemporal - moments in time which can be isolated, held in the memory and recaptured when needed. They are like events which fill up spaces in time.

The problems with this approach show up most clearly in Jarvis' (1987a) model as he addresses the issue of everyday experiences. Unlike other experiential learning theorists who merely acknowledge everyday experiences and concentrate on eventful experiences which can be described, Jarvis (1987a, 1987b) suggests that everyday experiences can be accounted for by considering their meaningfulness. Meaning, in his model, is conferred upon experiences which have passed (Jarvis 1987a, 72-77). He uses the term, biography, to describe the memories of all a person's experiences, which are brought to bear when a person apprehends social situations, thus changing the situations into experiences. Everyday experiences which cause minimal or no disjuncture between a situation and biography are meaningful if reflection can be prompted, and meaningless when the content of the experience does not prompt reflection. What remains problematic in this approach is that it assumes that a person can be in situations which are devoid of meaning and that meaning can be conferred upon some periods of existence and withheld from others.

Considering experiences as if they were atemporal events raises the serious question of what is happening in people's lives when situations or experiences do

not count as discrete events. What happens in the taken-for-granted everyday flow of life which makes up the majority of our existence?

Researchers working within a hermeneutic phenomenological approach face different problems related to time and meaning. Commonly in everyday life we talk about sharing experiences through conversation, a shared joke or even a glance. That is not to say that when experiences are shared they are understood in exactly the same way by each of the participants. But such commonality of understanding in our practices and language point to shared background meanings already in experiences which can be revealed through interpretation (Heidegger 1962). This perspective holds that no experience is meaningless but there are some which may be more meaningful than others. In this vein, Benner (1984), following Gadamer's (1975, 317) notion of "'experience' in the real sense" as always being a negation of prior understanding, selects for analysis those experiences which stand out in a nurse's mind as having affected her and her practice.

In hermeneutic phenomenology, the temporality of experienced situations is depicted as directional and relational (Heidegger 1962). Unlike conventional accounts which use the metaphor of space to depict time as discrete serial events, Heidegger uses the metaphor of activity to express temporality. Understanding time to be activity, the rhythmic or temporal feel of experience is recognized to be important (Clandinin 1989). However capturing the actual temporal nature of the experience is exceedingly difficult to do when experiences are transposed into a narrative in verbal or textual form. Nuances of timing and pacing, crucial components in the meanings of everyday human actions, can only be pointed to in descriptions of experience: they cannot be completely captured.

Although the location of meaning and the temporal sense differs markedly between the experiential learning models and the approach of hermeneutic phenomenology, the question posed earlier also arises here. What is happening in the taken-for-granted flow of life as it relates to experience?

Telling About Experience

In the experiential learning models, experience is essentially considered to consist of raw data: it provides the basis for reflection and the place for assimilating or

using newly formed concepts. Boud suggests that reflection is the way in which learners "... process the experiences they have...." (Boud 1987, 233). In considering experience to be an event made up of raw data, the models suggest that experience is straightforward; something which can be recalled as a piece by an individual. A particular experience can be replayed in the mind's eye and such replaying becomes the first stage of reflection. For instance, in an educational context, a person is asked to "return" to the experience:

"... to recall in detail exactly what happened: who they met, who said what, how each person reacted, what they felt at each point in time, what occupied their attention, what else was going on. The idea is to recapture, in as much detail as possible, the full experience of the event and the reactions of all those associated with it." (Boud 1987, 233)

Implied here is that experiences are lying as entities in a person's memory and are there to be recaptured. Yet whilst recalling experiences in some detail would indeed appear to be feasible, it seems unlikely that it can be as complete as Boud suggests. The notion of "the full experience" is a bit misleading. As we go through life, we are tacitly aware of more than can be accounted for in verbal reconstructions of experiences (Polanyi [1958]1962). In telling about any experience, we can relay only a portion of what was going on at the time. It is illusory to think that the entirety of an experience could ever be re-created through retrospection, even though accounts do provide a fruitful source of understandings, meanings and practices.

This view of experience as a discrete event, a collection of data which can be retrieved as it was deposited and then processed, also belies the interpretative nature of experience. It suggests that there is a subjective reality to an experience and that intervening experience and the situation which provokes the recollection do not influence what is recalled, nor how it is recalled. Such a view also points towards a notion of subjective experience in which experiences are only revealed through what individuals say about them.

The interpretative character of experience and recollection is also overlooked when it is suggested that one can "refrain from making judgements" in describing experience (Boud, Keogh and Walker 1985, 27). It fails to recognize that even in the act of describing or telling, the language used reveals the person's

interpretation of the experience and judgements about what to tell and how to tell it.

Researchers using hermeneutic phenomenological approaches attempt to understand the meanings and "meaning structures" of experiences as they are lived. Descriptions of a particular situation or event as it is lived is used as the source of understanding (van Manen 1984, Polkinghorne 1988, Benner 1984). Such situations or events are usually in the past, although sometimes actual, ongoing practices are included. Descriptions of experiences are usually gathered or created in the forms of narratives, schemes "for linking individual human actions and events into interrelated aspects of an understandable composite" (Polkinghorne 1988, 13). Although no claims of direct correlation of the narrative to the actual experience are made, narratives are held to provide insight into the experience as well as to give form and meaning to the experience itself (Polkinghorne 1988, Allen, Bowers and Diekelmann 1989). The interpretative character of these descriptions of experience is acknowledged. Missing from these researchers' works, however, is an examination of the form in which experience is expressed. The narrative form is taken as usual and unproblematic. It is further assumed that the emotions felt by the person during the experience can and will be expressed.

The temporal nature of experience is revealed in the way we speak about experiencing. For ourselves, and for the Sisters in the study whose experience I will explore shortly, everyday experience is spoken about as something fluid, in the past as well as in the present. But when we talk about our "experience" it is usually of experiences which have already happened and which have stood out enough to be remembered. We seldom consider ourselves to be experiencing in present 'real' time. This is perhaps because we take it for granted, and only talk about it when we stop to actively reflect on what has already happened. Experience as we live it on a moment-to-moment basis is seldom narrated in the form it is actually experienced. We make leaps forwards and backwards, making connections between the past and the present and among experiences in the past. Connections which we actually make between past experience and present action can only be guessed at, and can only be incompletely described. Indeed, the Sisters often found it impossible to make a concrete link between their current practices and experiences which had informed them. They recognized however, that real but tacit links were there.

The largely non-verbal nature of many practices also poses a problem for the depiction of experiences. Whilst we may have many experiences we put into words, there are many others that we cannot even come close to describe fully with words. Consider the feeling of hitting a golf ball just right, the smell of bread baking, or the feeling when a close friend dies. Words which are available to us often are inadequate to describe such bodily and qualitative distinctions in experiences. This inability to completely capture nuances of everyday practices and experiences points to the difficulty of describing experience, both past and ongoing, and to understanding connections within experience.

Given these problems: of understanding the nature of everyday experience; understanding the relationship between experience as people live it and how they tell about it; and the difficulties in capturing experience as it is happening, what can one say about the experiences of nurses in everyday practice?

It seems from the literature, and from observing and listening to the Sisters that they concomitantly draw on experience and are adding to their experience whilst they work. Their everyday practices form the basis of their experience: they are also adding to their experience whilst they are practising nursing. Even though it seems impossible to completely capture experience, it seems possible to capture something of everyday nursing by examining ongoing practices as well as accounts of experiences in practice.

CAPTURING THE SISTERS' EXPERIENCE

Before going on to explore the Sisters' experiences, it is useful to describe the nature of the data on which the following discussions are based. As it may be recalled from the discussion in Chapter 4, when the research started, it was my intention that the interviews would be foreground or primary data. The material arising from the participant observations would be background material, used only as a way of understanding the context within which the Sisters practised. I felt the observations were necessary to become familiar with practices, organizational constraints and opportunities which informed the Sisters' accounts of their experiences. It would assist a meeting of 'horizons' during the interpretation.

The problems inherent in understanding experiences from narrative accounts soon became apparent. There were marked discrepancies between the accounts and the fullness of the Sisters' everyday practice. The accounts were consistent with what I observed them doing: the picture of their practice which came across in the interviews was very similar to what I saw in everyday practice. However, there were many things happening in practice which I found to be remarkable yet the Sisters found commonplace and not worth mentioning.

The difficulty of describing connections between past and current experiences also became apparent as the Sisters had great difficulties telling how they came to be able to do some of the things they found to be commonplace. "Just experience" was often the response. Seldom did the Sisters report drawing on whole situations as they met current situations as Benner (1984) postulates. More often, connections between the past and present were a look, a phrase, a feeling, or something they could not describe beyond "experience".

The Form of the Narratives

The shape and character of the Sisters' narrative accounts of past experiences are also different from those reported by Diekelmann (1989), Benner (1984) and others undertaking research using the "significant experience" interview guide (See Appendix 6, Interview 1). Unlike those researchers, I was able to gather few well-formed narratives, "paradigm cases", but the Sisters did talk at length about memorable patients and experiences. It was sometimes difficult to get the 'full' situation in a coherent, narrative form, including many details about what was going on at the time and how the Sister was feeling. The Sisters also had great difficulty telling me about a time in which they "made a difference" to a patient. At the same time, the difference which their care made to patients was evident (and recognized by the Sisters) in their discussions and ongoing practice.

It is difficult to unpack the possible reasons for the differences in the form of the narratives between this research and that of Benner and Diekelmann, but the differences point towards possible features of the Sisters' experience. One feature is the influence of culture. The form of the accounts about experience may have been influenced by what is often called Scottish reticence. When asked to tell me about a situation in which she made a difference to a patient, one Sister said, "It sounds awful boasty, this, Martha" (Int. 4-1: 1). Unlike American nurses, whose

culture and educational programmes encourage them to relate experiences in some detail, Scottish nurses are not used to doing this. Even in educational situations, nurses are often reluctant to talk about experiences which they do not consider to be major, or experiences which they think the listeners would have experienced themselves. Teachers of nursing not only find students reluctant to bring experiences to share in seminars, sometimes they also find it difficult to get students to discuss their experience in sufficient detail to be able to examine its significant features (Stewart pers. com. 1990). Other researchers have noted similar differences between Americans and Scots in reporting and addressing feelings in health care situations (Strong 1979).

A second feature is the effect of experience itself. As will be discussed shortly, the form of the narrative appears to be related to the nature of the experience. The Sisters related remarkably few "firsts", such as a first death, or other dramatic, moving stories. Because I focused more on recent experience in the second and third interviews, and sought links to everyday practice in the interview probes, there were fewer emotion-laden, fully expressed experiences than perhaps there might have been had I persisted in seeking critical incidents (Flanagan 1954). In contrast, Benner concentrates on events which stand out to nurses and places a much smaller emphasis on the moment-by-moment taken-for-granted experiences (Benner 1984, Benner and Wrubel 1989).

Insights into Experience

The Sisters' accounts cannot be said to completely match their experience because feelings may not be expressed fully, and details may be a fraction of what went on, but nevertheless some insights into experience are certainly gained. Because experience is fluid and much of it remains hidden, it is impossible to entirely indicate the features of experience. The interviews give insights into the Sisters' experiences of practice in the past, their comments on recent practice and connections which they are able to make (or not able to make) between current and past practices.

When observing practice, I can presume that experience is being drawn on, but I cannot see the potential in the current situation which is there to be drawn on. Indeed, neither can the Sisters. They cannot say what of their current experience may ultimately be drawn on, nor how it will be drawn on. In other words, they

cannot determine what aspects of today's practice will join that ever-changing, amorphous body that they refer to as their "experience". Although there are some exceptions, I also have (as do they) difficulty saying what portions of current practice appear to be drawing on past experience. The connection is not and cannot be entirely clear. Having said that, what I do have in the field notes are insights into how the Sisters are working, their comments on their current practice, and what their current nursing practice looks like. Importantly, I have been able to capture something of the flow of practice over a few days at a time.

The interviews and observations allow the unexamined - what experience means to these Sisters and how practice and experience move together - to be examined. In looking at how they currently practice, and in hearing about their experience, I am speculating that they are drawing on something; drawing on it in particular ways, and that *it* came from something not unlike the practice I saw.

WHAT COUNTS AS EXPERIENCE

Two ways of understanding experience emerge from the Sisters' descriptions. One is of experience as an entity, a possession of the person, "the experience that you've gained...." (Int. 5-3: 31); "I don't have enough staffing, that is, experienced staff" (W9D2-1: 17). This sense of 'experience' is captured, for the most part, in retrospective accounts of experiences, and occasionally in present actions or future intentions: "[Y]ou can get that experience today. It is good to get it early in your training" (W7D2-1: 8). This sense of 'experience' is a result of the process of 'experiencing' (Gadamer 1975, 316-17).

'Experiencing' expresses the other way of understanding experience: experience as an ongoing process, of acting in a situation, in an historical time and place; it could be said to be the process of being. This sense of experience, I suggest, is best expressed as *experience as movement*, as it encompasses both ongoing, dynamic activity as well as a change in the person. In this vein, Sr. Aitkin talks of "...the experience of talking to people" (Int. 1-3: 47). Experience in the first sense, experience which we possess because we have had it, grows out of the second, experience as a process. But it is not as simple as saying one is in the present and the other is in the past, nor saying one is a product and the other is a process. The two are intertwined. It seems that experience which we have had is not static, but is in continual flux; it is inseparable from experiencing the present. This emerges

in the Sisters' discussions of their experiences, as well as in their everyday practice.

The process of experience is revealed through examining moment-by-moment practice and the connections between experience and experiencing. As a process, experience involves learning. In Gadamer's explanation of experience as the turning around of preconception, learning is presumed in the motion whereby previous experience is negated by new experience (Gadamer 1975). He does not address learning directly. Benner (1984) and Dreyfus and Dreyfus (1986) also address learning obliquely. The Sisters however, talk directly about learning in practice. In their experiences, learning appears to be conterminous with experiencing as well as being an outgrowth of experience.

What counts as experience then is experience as movement: the process of experiencing in addition to experience as a result or event. Both senses of experience emerge in the interviews and observations. Before moving on to the features of experiences and experiencing, it may be useful to explore how experiences are revealed in the Sisters' accounts and their practice.

Unlike the unitary picture of experience which emerges in Benner's exemplars or paradigm cases (Benner 1984, 1987), and in the writing of the experiential learning theorists, the Sisters' experiences take many forms. They are not all 'of a piece' within a defined time frame. Some are, but more often they are more amorphous and discontinuous. Their experience can not be neatly categorized; however, the following examples and descriptions are presented to show something of the diversity.

"I've Never Forgotten": Watershed Experience

Watershed experiences are unforgettable experiences which stand out in the Sisters' minds. They are Benner's paradigm cases. In the following interview excerpt, Sr. Jarvis describes an experience in which she learns about early warning signals of a serious postoperative complication.²

² See Appendix 7 for the editing convention used to edit field notes and interview transcripts.

Sr. Jarvis: I remember quite clearly a patient who went into clot retention after a prostatectomy. And this is quite a long time ago because it was when I was a staff nurse in the unit, when I was quite junior at the time. And this was something that worried me greatly because there was no one else around to whom I could turn. No other staff nurse and no sister.

And this man's catheter wasn't draining and I had to try to wash it out and couldn't get anywhere with it at all. Couldn't get anything in or out and the patient was in EXTREME pain. I very soon realized that I wasn't going to be able to do anything that would make any difference at all. So we phoned to theatre to ask to speak to a doctor because the Resident wasn't around. And the Registrar came to see him. And he tried to wash the catheter out as well and decided that there was no way we were getting anywhere and he'd have to go back to theatre.

But it was something that I've never forgotten because it brought to me very clearly how important it was that these catheters drained after theatre and how very quickly if they didn't, you'd end up with a patient that had a bladder full of clot that was going to have to go back to theatre and have another operation to remove it. And it's something that ever since, I feel I'm always emphasizing to the nurses how they MUST watch the catheters' draining, how they MUST make sure the irrigation is always running and never never stopped. And because of that, having seen what can happen if it doesn't.

M.M.: Mmm. Can you can you tell me what happened up until that point that affected you so so much?

Sr. Jarvis: I think because for the first time ... I was expected to know what to do. It had been the first situation where I didn't know how to cope. And I couldn't just turn to somebody and say, "I'm not happy about this; what do you think? I had to decide that this was far from right and that somebody, medical staff would have to come and see it.

M.M.: ... Do you remember what other staff was on that night?

Sr. Jarvis: I don't remember exactly who were on with me but obviously were students for there to be no other qualified nurse about. And obviously they wouldn't be expected to know any better than me about that sort of thing. It was specialized.

I think you always feel protected and then all of a sudden there has to be a situation where YOU have to make the decision. It's lucky you know enough how to do it when it comes.[laugh] But you don't get trained for it.

M.M.: No. Do you remember how you felt at the time?

Sr. Jarvis: Extremely anxious. And when I had spoken to the doctor on the phone I then went back to the patient to make sure that it WAS necessary for him to come and I wasn't making a fuss. Because I was quite new and and I didn't want to look to be stupid.

So of course I was then extremely relieved [laugh] To find out that there wasn't something that I could have done anything about.

M.M.: Right ... Have you been in situations since that that has been brought back to you?

Sr. Jarvis: I've been in several situations since whereby I knew that if we didn't watch very carefully that this same thing would happen to this patient as it happened to another one.

And I've also come close. I think two patients since who have, in fact, been in clot retention and ... I've had the medical attention far quicker than when I first had to deal with it. (Int. 10-1: 6-9)

This experience speaks of several things for Sr. Jarvis. First, it is an experience of coming to know about a specific aspect of nursing care in her specialty. In a secondary way, she is learning about herself in practice. This experience speaks of gaining confidence in her perceptual abilities and in her capability of making important clinical decisions on her own. She learns that her judgement is sound; she does not call the doctor unnecessarily. Second, she learned specific skills from this experience early in her practice which she continues to use as she copes with similar patients, monitoring them closely and intervening more rapidly. Although she would have known about postoperative bleeding before, Sr. Jarvis can pinpoint the beginning of her current know-how about taking action to this instance. Third, it is a first experience, one in which Sr. Jarvis has responsibility and has to make a decision. At the time, she is in her first ward as a qualified nurse. The experience is emotionally charged; Sr. Jarvis' anxiety comes through. Fourth, this experience stands out. She has vivid, specific memories of a

particular situation. Her account of the experience is specific, full and lucid. What Sr. Jarvis has learned from this experience has stayed with her. It is noticeable in her current practice, particularly in how she guides students in monitoring patients.

Watershed experiences are related by all of the Sisters in the interviews, usually the first and second interviews. As the Sister relates them, the context is full and the telling is lucid. These experiences have most likely been told before. One Sister describes them as "stories". The time frame is exact. The Sister places the experience in relation to where she was at the time. Many such situations occur at an early part of the Sister's career: during training, in the first staff nurse job, the first time in a new clinical area or early in the experience of being a ward sister. The experience usually occurs over a relatively short period of time, within a shift or at most, a few days. The topic of the experience is significant. Often, it is the first time the Sister encounters something, for example, her first death. Sometimes, it is of a magnitude she has never experienced before, or has not expected to encounter, for example a horrendous gangrenous wound developing from a rectal abscess (Int. 9-2: 1-3). Usually, it is a situation in which the Sister's understanding is radically challenged.

Typically, the experience is emotionally charged. This comes across in the telling, even though the situation may have happened decades before, such as seeing a child die for the first time (Int. 4-1: 20). Often the feeling is one of high anxiety, and is linked to feelings of not coping. Occasionally, there is a feeling of joy and great pleasure, of when, for the first time, something that had been a struggle before came smoothly and really goes well. In the accounts, there is a greater focus on herself, how she feels, and what impact the situation is having on her. That is not to say that she does not describe the situation vividly. Often small details are included, like the colour of a person's eyes or hair.

For the most part, the meaning for the Sister of Watershed situations lies in a change in her understanding: she is brought face to face with her own competence or incompetence; she realizes the importance of an aspect of care she took for granted or was unaware of before; she understands the impact her actions can have on a patient; she realizes the effect a patient can have on herself. Many of these experiences concern discrete skills or are the beginning or early part of gaining a complex skill. Sometimes the experiences stand on their own, but often

the Sisters consciously make links between these experiences and their current practice.

"It Comes Running Back to Me": Resonant Experience

When asked to relate specific experiences, the majority of experiences related by the Sisters were resonant experiences. Some were told in the first interview; they make up the majority of experiences related in the second and third interviews. In many instances they take the form of experiences with memorable patients, or with patients currently or recently in the ward. Other times, they take the form of experiences with staff members, doctors and others. These experiences may have taken place some years previously, but they are usually recent, within the last year or two. In many instances, the experience comes out piece-meal, often hesitantly to begin with. The Sister describes a person or a situation, but it is clear in the telling that the aspect being related is only that, an aspect of the Sister's whole experience. In these experiences, the time span varies greatly. The experience may take place within a day, over several days, or even over months. It often spans the time the Sister was acquainted with the patient.

The emotional content of these experiences is markedly less than Watershed experiences, but it is not absent. In some experiences, the Sister's discomfort or anxiety is relieved when she comes to understand the situation differently. In other experiences, the Sister's care and commitment is evident; it is sometimes accompanied by sadness, pleasure or satisfaction.

In these Resonant experiences, the Sister is coping smoothly; she is confident in her practice but is often wrestling with a nursing problem. Her focus is outside herself, on the patient or her colleagues. Details of the experience concern the relationships between people or aspects of the particular problem. Often the meaning of the situation for the Sister lies in how patients and their families cope with illness. It also may be an insight gained gradually over time about her own practice. The Sisters sometimes say, "I finally realized". Sometimes, embedded in the situation are understandings which the Sisters may not have thought about before, perhaps because they have not felt the need, or because the opportunity has not been there to relate the experience as a whole.

In the following interview excerpt, Sr. Baxter makes a connection between a Resonant experience to a taken-for-granted practice. The taken-for-granted practice falls within the next group of experiences, the Bits and Bobs, which form the majority of everyday experience. In this excerpt, it is easy to see how difficult it is to grasp ongoing experience and to make definitive links within experience. Sr. Baxter describes her experience of timing and pacing a conversation with a 'difficult' patient, Mrs. Harrison.³ The conversation took place the previous day and was only discussed because I questioned her on it.

M.M.: [...] You just took your time to do it. Were you aware of that at the time?

Sr. Baxter: Un hun. Probably. I would get some responses from the way Harriet looks.

Oh you can tell. She smiles sometimes. Sometimes she looks a bit, not strange, a bit more um positive when she's determined not to do something. Or you can tell the look of determination. That means she's got what she wants to do on her mind. And when [...] I see it coming or I see that look of questioning on her face then I know that that's enough. I know that I don't go any further.

It's like this morning when she wouldn't take her medicines. [...] She was taking tiny wee sips. And if I had forced it she wouldn't have touched it at all. I think now, that's the feeling I got.

That if I pushed through then she would just say, "Well I'm not.." She would begin to use her adjectives again. "I'm not going to take it." And [...] I think she wouldn't have touched it. So it's better to let her do it in her own time. (Int. 2-3: 5-6)

In this experience, Sr. Baxter attends carefully to Mrs. Harrison's face and notices her responses. Sr. Baxter gets feedback on her actions, understands the meaning of Mrs. Harrison's responses and alters her actions to meet them. She has not always had this ability. She remembers not having it when she was a qualified staff nurse of about five years experience, newly working in the neurosurgical unit.

³ For ease of reading, the excerpt has been edited. The full interview excerpt is provided in Appendix 8 and provides an illustration of how I have edited the excerpts which appear in the thesis.

Sr. Baxter: [...] And I hadn't long been there and and insisting that patients must take their medicine. You sign for them [...] to say that they've taken them and if the patient hasn't taken them, you've signed it. So that in effect is wrong.

[...] And there used to be patients who [...] became quite restless because of their illness and you couldn't reason with them. Somehow these patients had to get their medicines. And I felt that I had this right for the patient to take it whether they wanted it or not.

M.M.: Mm hmm. Can you remember....that turning point for you?

Sr. Baxter:I can't. I can't say that it is something that's quite foremost in my mind. [...]

But that turning point came in dealing with people who, were agitated; whom you couldn't communicate with as easily as, I suppose, as with Harriet. [...] Somehow over that period I came to the, not conclusion, but I understood that people were people. And that you had to go with them as people. And that you've got twenty people on the ward and they're all different. And whilst you can't have routines for every one of them to their own individual needs you've got to try, and to a certain extent go with them.

[...] I'm aware of it happening. I don't know when. But I'm aware of now being different from how I used to be in that respect. And I think that was when I realized that they were people. And it didn't matter because you've signed a piece of paper, as long as they took it. [...]

And there were some situations you approached ...differently from others. And I-I don't know. That's something that I .. sensed. You know sometimes that if there is somebody who won't do anything, you've got to be firm. And maybe had Gladys [another 'particular' patient on the ward] been here for longer and she wasn't going to take her medicine, then that for the long term couldn't persist. And you'd have to think of some plan to help her.

And it may be that you would have to be a wee bit moreum ...forthright in some things, in some respects. And give them leeway in others. Because over a long period of time maybe that wouldn't be the approach every time. (Int. 2-3: 6-8)

Sr. Baxter's experience of coming to know people as people could be interpreted as an odd experience to have five years after qualification. The nursing textbooks stress that nurses should treat the person as an individual and the Sisters endorse this general principle.

However, this Resonant experience reveals something of the deepening of understanding, not only of coming to know people as individuals, but also of practising from that understanding, particularly in complex circumstances. This example speaks of coming to a new way of knowing-in-practice. Sr. Baxter does not throw away the text-book knowledge of medication administration, but looks beneath and beyond to something more complex - to what is possible in order to care for the person in a way which most suits that person. Her focus moves from concern about her practice to looking through her practice directly to the patient. Sr. Baxter is telling about changing to a flexible stance. It started with the issue of giving medications to brain-injured patients, and has gradually become part of her practice with all patients. Up until this point for Sr. Baxter, caring about the person was one aspect (amongst many) of what she was trying to achieve. Her change of focus depicts a qualitative leap in her practice. She becomes able to approach the person as an individual; it now suffuses everything she does. It is evident in her style of practice, which is often one of negotiation. Her practice presumes a trust and respect of the person.

Her description is quite different from Sr. Jarvis' description of her experience. Firstly, unlike Sr. Jarvis who centres on a specific aspect of her practice, Sr. Baxter's experience concerns a more far-reaching change. Sr. Baxter recognizes a change in herself. "[I am] different from how I used to be". Changes in a specific area of practice may indeed prompt changes in other areas because of an increase in confidence, for example. On the other hand, a change in oneself such as Sr. Baxter describes, differently enframes all of her future practice. Secondly, whilst Sr. Jarvis recognizes the experience as a time of specific change, Sr. Baxter doesn't remember changing: she only remembers when she was not as flexible. She relates it to a time when she was having difficulty with an inflexible response, but not to a particular patient situation. I can presume that in the neurosurgery ward more than one patient did not cooperate with nursing care. Thirdly, she does not relate it as a first time event. She was already a seasoned staff nurse. Fourthly, the situation and process are not easily told and are not "something that's quite foremost in my mind". In telling me about it, Sr. Baxter hesitates and repeats

herself. Her sentences are not as fluid as they often are. Her experiences of people have prompted a subtle but important change in her understanding of people, of her actions with them, and in her understanding of herself. It has taken place over time and is not easy to describe. It has come,

Sr. Baxter: With experience. Just with with dealing with people like Harriet and Gladys that are quite determined in their own way. In the end I found out that you know, you don't go in.. You, you get more by going at their pace. (Int. 2-3: 6)

"Just the Bits and Bobs": Taken-For-Granted Experience

Taken-for-granted experiences which happen all the time in everyday practice make up, by far, the majority of nursing experience. However, the Sisters talk about them only in the field notes and in the third interview where I asked them about specific aspects of their practice which I had observed. They are the recent and 'real-time' experiences. Often what I had observed in detail is related by them in the broadest of terms: "just a routine day", "just an exploratory conversation". Rarely is there a more detailed description of the complex interactions I observed. Sometimes, the Sisters had forgotten the occasion, but more frequently, it had not stood out enough to talk about, except in the context of a question on something else.

The time frames of the experiences are momentary, a scrap of conversation, a comment, even a look. However, they are embedded in broader experiences of relationships with patients and colleagues. The emotional level of these experiences vary, with calmness, "the usual" frustration, sadness, puzzlement and pleasure all being among the emotions present. The Sisters are all coping in these experiences with a greater or lesser degree of comfort. When the Sisters tell about these experiences, the focus is rarely on themselves, on their own experience and feelings. They play only an incidental part. The focus is on the patient or colleagues and their responses in particular situations. The meaning of a situation primarily lies in practice, in understanding patients and how to accomplish the work of the ward.

Through these Taken-for-granted experiences, the Sisters' skills and understanding are reinforced, extended and refined. They form and transform the Sisters' everyday practice, but are usually hidden, appearing only in discussion at

handover report or during informal discussions among nurses. Some may come to light however, when the understanding arising from these everyday practices and taken-for-granted knowledge comes to a point that it forms a new whole, and the Sister expresses it as an experience which resonates with her.

Thus far in the discussion, different kinds of experiences have been distinguished. I have suggested that experiences take many forms and have delineated three kinds of experiences to demonstrate the range. These three are: *watershed* experiences, which are vivid, highly memorable, emotionally charged, and specifically meaningful for the Sisters, and often concern first-time situations; *resonant* experiences, which are less emotionally laden, are the result of cumulated taken-for-granted experience, often focus on patients or a gradual change in self-understanding and need prompting to be recalled; *bits and bobs*, the taken-for-granted experiences which happen all the time, have a relatively even emotional tone, concern the ongoing practising of the Sisters, are often forgotten soon afterwards or are not considered to be important enough to tell about. I have further proposed that experience has to do with change, with the deepening and broadening of the Sister's understanding of herself, her patients and her practice. In the next sections, aspects of the ground of experience as movement will be explored.

AWARENESS OF EXPERIENCE

A question which remains unaddressed in both the experiential learning literature and the phenomenological literature on nursing experience concerns peoples' awareness of their everyday experiences in practice. How aware are the Sisters of their ongoing experience?

In many instances, the Sisters are conscious of their experiences and the changes in understanding which accompany them. This is particularly so with Watershed experiences which prompt sudden insight. Through the experience reported above, Sr. Jarvis becomes aware of her new understanding of a particular postoperative complication, the development of a clot in the bladder, and how it shows up in the patient. Although not explicitly stated, she newly recognizes her powers of assessment. Her confidence increases and in subsequent situations, "I

knew ... that this same thing would happen...." Her experience in the earlier situation prompts her to notice and act differently. In a subsequent situation (Int. 10-1: 9-10) she realizes with the "first syringe of water" that she is facing a forming clot, so gets the Registrar "to come and see him". Her prompt action averts the need for the patient to return to theatre. Experiences in subsequent, similar situations confirm her understanding and actions, and reinforce her confidence in her perceptions.

At other times, the Sisters are not explicitly aware of their experiences. Such experiences confirm previous experience, or encompass subtle or imperceptible changes; prompting awareness only when the accumulated movement is significant, or a new situation calls forth a response from the Sister that she did not realize she had. Awareness of an earlier change may only come in retrospect. That does not mean that they have not experienced at the time. Unlike Benner's (1984, 36) contention that experience is the active "... refinement of preconceived notions and theory...." rather than the "... mere passage of time....",⁴ the Sisters are engaged in many aspects of practice upon which they may not actively reflect but which form part of their experience. The way in which this occurs is discussed through the next three chapters.

Frequently the Sisters are not aware of their practices until they are called upon to tell about them. Such telling can prompt a sudden insight. Sr. Fraser slows her pace to watch a patient walk down the hallway, moving slowly and holding onto the wall (W6D4: 8). My asking a question about what she was thinking prompts reflection on her practice.

Sr. Fraser: I didn't even know I was doing it. [...] I'd never realized that you're automatically assessing them all the time. You're not even thinking about it. You're doing it. (Int. 6-3: 33-34)

Since my questioning her, Sr. Fraser is "now doing it consciously". She contends that knowing her practice has "... not made any difference to the outcome...." or changed her practice. However, being aware of her practice allows her to point out to students the effectiveness of judging a patient's progress: "... just watch them on their own when they're not [aware]" (Int. 6-3: 35). While she watches the

⁴ In *The Primacy of Caring*, Benner refines her use of experience, particularly in regards to life experience. "Experience does not mean simply a passage through time, it means the way in which one is changed, for better or for worse, by what happens to one. Life experience changes meanings, understanding, and skills." (Benner and Wrubel 1989, 104)

patient in the hallway, Sr. Fraser notices and understands the meaning of the patient's gait and comportment in terms of her progress towards recovery from ear surgery. She is experiencing the woman and the situation. Reflecting on her practice affords Sr. Fraser a *new* experience, of coming to be more aware of her own practice.

The Sisters are experiencing all the time, even in conversations which quickly fade from memory and may not be called forth later in reflection. Sr. Baxter's conversation with Harriet is a good example. She notices throughout the conversation; her understanding of Harriet deepens. Her experience in the conversation also confirms her knowledge about an effective approach to take with Harriet. In such low key situations, which form the majority of experience, the Sisters' understanding is confirmed, extended and refined. While they may not be particularly memorable, these taken-for-granted experiences form the basis of the "realization" which comes "with experience".

Although a Sister's practice and knowledge can be made visible and differently accessible to her, it is not a necessary prerequisite to refining or expanding it. Tacit knowledge may be refined and deepened without becoming explicit. Sr. Baxter has refined her tacit knowing of Harriet's "look of determination" to the extent that she can see it coming. It is only when she recalls the conversation in the interview that she makes the knowing explicit. Even then she calls on my shared understanding of a "look of determination" as her tacit knowing cannot be made fully explicit. Sr. Baxter's understanding of Harriet's looks would continue to be refined in further encounters with her.

Specific changes in understanding which occur during the course of a day may be quite small. It is only when they accumulate to such an extent that awareness is prompted that they come to consciousness and can be named. It seems that the Sisters become aware of changes when they form a pattern, when practices are pointed out to them, or when they are reflecting on past or future action. Understanding may take a considerable time to change; the change may be tacit. Sr. Baxter cannot remember when she changed her approach to people but knows that a change occurred. At a certain point she "sensed" a need to approach situations flexibly and "in the end", found out "you get more by going at their pace."

Whether or not the Sisters are aware of specific experiences, they show a certain openness to new experience and to finding new meanings in past experiences. How this openness manifests itself will be explored in the next chapters, but it may be useful here to explore the possible ground of this openness to experience.

BEING OPEN TO EXPERIENCE

Underlying the Sisters' receptivity to experience appear to be two phenomena: one is being in a state-of-mind, or mood and the second is being attuned to the meanings in experience. They are closely linked. As Heidegger says, we are always in a mood; we always are in a state-of-mind which allows our encounters in the world to matter to us (Heidegger 1962, 175-176).

The Role of Mood and Emotion

In their accounts of their experiences and in their everyday practice, the Sisters show moods: of interest, of anxiety, of surprise, of pleasure, of sadness, of frustration, of anger. We usually refer to feeling or emotion when we speak of the type and intensity of feeling of the Sisters' state-of-mind or mood. Whilst the mood may be neutral, there is never absence of emotion.

Different situations evoke emotions of varying intensity. In the accounts of first time encounters or other Watershed experiences, such as Sr. Jarvis', the emotional level is high. Sr. Jarvis remembers being "extremely anxious" about the patient and making a good decision and then "extremely relieved" that she had made the right decision. As she relates the experience the intensity of her feelings at the time come across. They remain vividly part of her experience. Such experiences are powerful and emotionally charged, often with a sense of drama. They stick in the Sisters' mind and can be recalled in great detail decades later.

Sr. Dunn: But I think that these patients and other patients when you're a young student nurse must have made a great impression on you.

[...] Because you can still remember these instances. And I think it's just all a matter of caring really. Because you cared.. It's not that you were upset. I mean you couldn't cope and you felt so sorry for them, because that's not

professional. But then you're just learning to be a professional when you're a student aren't you?

[...] And I think it was just the fact that you cared and 'wasn't it sad really', and it just stuck in your mind. (Int. 4-2: 44)

These first experiences of coping under pressure (or not coping as the case may be) and of being very close to patients are highly memorable. Fewer such instances stand out later in the Sisters' careers.

Sr. Calder: You know what I mean? The first time when these ones happened to me it meant something, because I was frightened you know, it did start the adrenalin going but ooh.....

[...] I don't remember it [now] in the same way at all. And you know I'm trying. (Int. 3-2: 7)

As the Sisters have more experiences and learn to cope better, fewer situations are infused with the same level of emotion. Indeed, situations which at one time were sources of great anxiety and stress are now taken for granted. The Sisters know they can cope; they have confidence in themselves. As the Sisters gain experience they may find situations frustrating or difficult but they are not as emotionally charged. That is not to say that the Sisters become less emotionally involved in their work and situations and patients matter less. Rather, through experience the Sisters have developed a capacity to respond differently.

In accounts of more mundane experiences, the Sisters' feelings also come through. Describing a situation in which a staff member does not arrive at work one morning, Sr. Grant expresses her feelings:

Sr. Grant: ...A battle was changed by the absence of one of our staff. [...] It usually means that everybody will have to do a little bit more. And since we run so close to the bare minimum anyway that can be enough to make you understaffed and that's a pressure that's felt by every member of the staff. [...]

.....Well, it presents a feeling of frustration. Because you can't meet your ideals or even approach your ideals. (Int. 7-1: 11)

The experience is not emotionally laden, but feeling is not absent. Sr. Grant is coping in the situation. By far the majority of the Sisters' experiences consist of situations such as these. Along with frustration and anxiety, pleasure and satisfaction comes through in many everyday experiences. For example, warmth and comfort comes through in Sr. Baxter's conversation with Harriet.

The Sisters' feelings in a particular situation arise in great part from their concern for the ward and care for the patients. While sometimes their feelings inhibit what they notice and how they act, feelings emerging from their involvement with patients and the ward also enable the Sisters to uncover the meanings inherent in their practice experiences (See also Benner and Wrubel 1989).

Revealing Meaning in Experience

Underlying the Sister's openness to experience is the possibility of grasping meanings inherent in the situations in which they find themselves. Meaning is always there in experience - the situation always matters to us in some way and through interpretation we understand a situation *as* something (Heidegger 1962). The Sisters' descriptions and practices give the *as* an expression (Ricoeur 1978, 154). The way in which a situation matters is revealed in the Sisters' experience through their interpretations of particular situations.

Sr. Baxter's interpretation of the meanings of the situation is revealed in her account. They are also revealed in her ongoing practice. Sr. Baxter's actions flow from her interpretation of the meaning of Harriet's facial expressions. She adjusts the timing and pacing of the conversation to accommodate the meaning she is finding there. "...[Y]ou can tell the look of determination ... when I see it coming ... then I know that's enough." Harriet's expressions and movements are salient, pointing to how she feels and what she wishes to do. Sr. Baxter captures the meaning in them, understanding when Harriet begins to feel pushed and what action to then take.

The meanings in situations are neither absolute nor static. Over time the Sisters understand similar situations differently. Things stand out differently and they in turn respond differently. What is salient and meaningful changes with new experience. When Sr. Jarvis knew she could recognize the early warning signals of a developing blood clot, the meaning of similar situations changed. They were

not as frightening; she knew what to look for and could act to prevent them. Her first time situation still stands out with all its vividness, although the meaning she finds in it may have changed.

Sometimes, a specific experience reveals new meaning in a particular situation. When I question Sr. Fraser about her thoughts while watching the patient walk, she sees new meaning in this everyday situation, not in what she is observing, but in understanding her own practice - that she does look all the time.

The reflexive nature of meaning in experience is further illustrated by Sr. Calder as she tells about seeing her first bedsore, which happened within her first two days of practice as junior student.

Sr. Calder: There may have been some reason why he had these bedsores, but it was right down to the, Och I'm sure it was to the head of femur. It was just the most awful sore in his side. After more experience I realized that there are some of them you can't prevent. Some of the sick patients that have laid at home, come in with bedsores. And, well, it has made me more conscious of bedsores and the treatment of bedsores. (Int. 3-1: 1-2)

Part of the initial meaning to her of this experience was how neglectful the nurses could have been. She understands this differently "after more experience" of patients coming into hospital with bedsores. There are also hints here that she acknowledges her own limitations in preventing bedsores. Sr. Calder's current practice reflects a continuing concern about preventing pressure sores: she sets up formal turning schedules for patients and is particularly vigilant for signs of skin breakdown, even with patients who are on the ward for only a day or two (W3D2-1: 7).

Situations contain a complex of meanings which can be grasped by the Sister. In relating experiences of caring for elderly patients who are receiving aggressive medical treatment at cardiac arrest, Sr. Calder recognizes the complexity of meanings inherent in the situation, for the doctors, the nurses and the family.

Sr. Calder: I mean O.K. We have got to help them to live, but we've also got to help people to die. It's part of our duty too. You know O.K. we save them for a week. But it's the quality of life during that week.

And what the family are going through. What are you going through yourself - nursing that old lady like that? What are you feeling about it? (Int. 3-3: 45-46)

Sr. Calder's understanding of the complexities of meanings in situations like these comes from her experiences as a nurse as well as being a daughter of elderly parents who have been gravely ill.

The meanings the Sisters find in practice situations thus comes from their experience outwith nursing as well as their experience in nursing. Their openness to experience is possible because they can interpret meaning in everyday situations.

It can be seen then that the Sisters' openness to experience is grounded in their being engaged in the situation, and in their being attuned to the meanings in experiences. Engaged in the situation, the Sisters are never devoid of feelings. Their feelings for the patients, the ward and their practice help them to be attuned to the meanings in their experiences in all parts of their life. Their involvement helps them to be open to interpreting situations in new ways; it allow for discovering new possibilities and meanings. The ward situation and the patients matter to them. Indeed, as it will be seen in the next two chapters, their involvement with the patient and in ward situations make it possible for the Sisters to practise as they do, helping the patients towards recovery and making the ward work for the patients, their families, the nurses and others.

"IT'S HAPPENING TO US ALL THE TIME": TEMPORALITY AND THE SITUATION IN EXPERIENCE

An argument has been made to consider experience to be a phenomenon with an embedded temporality. Rather than a series of discrete events in serial order, it is proposed that the interplay of time and the situation are both constitutive and evocative of experience.

Experience in Time

The Sisters are experiencing minute by minute and situation by situation. This comes through in their practice and in the interviews. In telling about their experiences, the Sisters illuminate an important feature of experience: that experiences occur within different time spans. In some instances, the time span of the experience is extensive. Sr. Baxter relates her experience with a patient, "an extremely difficult person to nurse", which takes place over the course of a year (Int. 2-1: 1-10). At other times, it is over a day or two, such as Sr. Calder's experience in obtaining a suitable referral to a rehabilitation facility for an elderly patient with complex physical and family needs (Int. 3-3: 7-11). An experience can also be as small as a brief conversation, a glance or a comment in passing. Sr. Calder remembers her experience of hearing a staff nurse call an elderly man "a cabbage" and the look on the man's face as "obviously he understood exactly what was being said" (Int. 3-1: 4). Different time-spans highlight the reflexive nature of experience.

Experience is not static nor immutable. As it will be seen to be in the next chapter, the Sisters' practice is situated in the present, but comes from the understanding afforded by the past and is acting towards the future. The stream of time influences the Sisters' understanding of current experiences, how previous experiences inform that understanding and the possibilities which are seen. In the movement of experience, different aspects of encounters with patients and others in the workday may take on new significance or may be forgotten. What is understood to be experience with a patient or in a situation, changes. It is this fluid nature of experience which makes it so hard to grasp.

Sr. Calder: [...] I suppose it has just come over the years with experience, really. I can't I can't specifically say. (Int. 3-3: 25)

The Sisters cannot recall when they acquired much of their know-how, particularly understanding which has been extended and deepened. As complex understanding contains so much taken-for-granted knowledge emerging from so many experiences, the Sisters often cannot identify a single incident in which their practice moved. They find it easier to identify a time when they did not have that knowledge, or when they gained an appreciation of the importance of

knowing, such as when Sr. Grant comes to realize the importance of her knowledge and role in medical rounds:

Sr. Grant: I have a much more important role on the ward round now than I used to have. They look to me. For instance, we get to the next patient and they look to me, "So what's new here?".

M.M.: Yes. Do you remember how that came to be?

Sr. Grant: I don't think it happened suddenly. I think it's something that happened progressively. And I think it's a mark of mutual trust that, you know, I'm reliable and my judgement's sufficiently sound. (Int. 7-3: 22)

Another time the Sisters can identify is when they realize that they have a new understanding of a situation, such as when Sr. Inglis realizes she is "home and dry", newly feeling comfortable as ward sister almost a year after a difficult beginning (Int. 9-3: 10-13). In their accounts and in their ongoing practice, the Sisters' experience is interlinked with particular situations.

"Patients Give us Experience": The Role of the Situation

The Sisters are in a position of having to cope with the routine and extraordinary demands throughout the shift, day after day, but as the next chapter will show, their focus of practice on the ward is the patient. Patients "give" the Sisters experience (Int. 6-2: 43); they set up the context for the Sisters to experience in a situation that matters.

Most of the experiences related by the Sisters in the interviews concern patients. Many of the experiences are of memorable patients, patients with whom the Sister had a particular relationship, or from whom the Sister gained some new insight into illness or into human nature. This opportunity to be so close to patients, to be with them in times of illness, of great vulnerability and of great strength, provides much satisfaction for the Sisters. They consider it a privilege to be able to be allowed into these spaces of people's lives.

In the interviews, the Sisters' sense of being in a place with the patients and those with whom they work comes through. It is perhaps this sense of 'placeness'

which best characterizes the situation of experience. It is particular and contextual. The Sisters are 'there' in the ward, with the patients and others. When Sr. Inglis says, "... it's happening to us ALL the time" (Int. 9-2: 14), she illuminates this character of the Sisters' experience. Their experience of patients is continuous, coming from their physical proximity and how they are 'with' patients as nurses.

In their everyday work, the Sisters' own knowledge and actions are transparent to themselves. They do not see their own practice: they see the patient and the ward.

Sr. Calder: I mean I think one can TELL the type of patient if you have been looking after them for years and years and more years. I think one can tell the type of patient [who] is going to be motivated to get on and get better. You know not just in this ward. In any ward. [...]

[In] the surgical wards - [the patient] coming in with an appendix. You knew the ones that were going to straighten up and walk or the ones that went ... like a half-shut knife. Ones who walk to get better; ones who ... will put an effort into it, will suffer the initial pain which there's bound to be. Until they get going again. Others of them sort of sitting down to it and holding all their muscles tightly. All. They get all sore then. And I think you can tell that type of patient in time.

[...] But, I suppose it's just over the years, [you] see them come and go. It's part of their character, I think that I'm seeing. It's not something I've developed. I think it's their character that I'm assessing more than anything else. (Int. 3-1: 9)

Sr. Calder does not consider knowing the patients to be coming from herself. They show her. Through taken-for-granted experience, the Sister deepens her understanding; her focus is on the patients and their responses to illness, surgery and hospitalization.

Being in the situation makes the knowledge vivid and understood. The Sisters can know about something, but not really understand the meaning until experiencing it. Sr. Jarvis would have known about the possibility of bladder clots, but until she is in the situation where she sees the clot forming, and where she has the responsibility for acting, her understanding of the signs of clot development and of her own ability in recognizing them is incomplete. Experience means actually being in a situation, acting in a situation, feeling the

emotions, noticing what happens and when it happens and being influenced by the effect of your actions with the patient or ward.

"I Had to do Something About It": The Interplay of Responsibility and Experience

Experiences which have made a large impact on the Sister often include the issue of responsibility. When the Sister practises, she is involved with the patients and the work of the ward. They matter to her. Having responsibility and feeling the commitment of responsibility sets up possibilities for action. In Sr. Jarvis' example, there was "...no one else around to whom I could turn." She had to make a decision; she had to act. For her it was the first time, "I was expected to know what to do". Before, she had felt protected; there were others who would take the responsibility. Although she knew "... enough how to do it", Sr. Jarvis had not had to make this kind of a crucial decision on her own before. Taking action because she *had* to was transformative for her understanding and her confidence.

Not only in first time experiences is responsibility pivotal. Responsibility inherent in her position prompts the ward sister to come up with alternative approaches to problems which arise in the ward.

Sr. Baxter: [...] [W]hen you then become the manager and the senior one and you have to do something about it. If you're aiming to do something about it, it's not as easy as you sometimes think.

And then you think, "Well, what am I going to do about it?" And I suppose from that point, you start and sometimes you look at things differently, you know. And maybe as a junior or a staff nurse, you always knew there was somebody else there, that you could hand it over to. And when that responsibility is yours, you see things differently. I mean, you can't just walk away and leave them.

That's not to say that you can always fix every problem that comes under way. I mean sometimes there are no answers. And you've got to do your best and you've got to learn to live with that. You learn to cope with it. And you learn to cope with it because you are in the situation. (Int. 2-3: 26-27)

Having responsibility prompts the Sister to act, and to consider the situation and its possibilities and limitations. Even extensive clinical practice opportunities in

basic or post-basic education courses may not be as meaningful as the experience which follows. Sr. Fraser tells about how her experience now is more meaningful because she has responsibility and is in situations in which "... basically all the care goes down to you" (Int. 6-1: 15). Having responsibility engages the Sisters. It commits them to action and in their action in concrete situations, they experience.

THE ROLE OF CONFIDENCE IN EXPERIENCE

Characteristically, the Sisters all have confidence in their perceptions and in their practice. Theirs is not bravado but a quiet confidence borne of experience and it is transformative of present experience. Because it comes from experience and forms experience, the movement of experience is most evident in the Sisters' discussions of confidence. Part of practising with confidence is drawing on past experience.

Drawing on Experience: Experience as a Resource

Implied in the movement of experience, is movement from one place to another. Experience as a resource speaks to the place from which experience moves and is revealed in the Sisters' discussions of situations in which they knew what to do. Experience is part of you, forming the horizon of your understanding. Sr. Ellis' comment, "... you're looking out of practice" reflects this notion. As a resource, experience can be pulled on, conveyed or used in the context of another experience.

Sr. Grant: I remember another patient who deteriorated over several weeks and died on the ward, maybe two years ago, who had similar problems with pain control. And I used my experiences from that time to apply to Hugh for strategies for helping him. (Int. 7-2: 10)

Experiences which are drawn on may be concrete situations, complete with their inherent nuances and feelings. They may, however, also be just a word, or impression, or scene.

Experiences in the Sisters' lives outside of the work situation contribute to the meanings revealed in situations with patients and on the ward. Sr. Aitkin

reappraises some of her own practices, including mouth care and anticipating patients' pain, on the basis of her own experience of being a surgical patient (Int. 1-1: 24-28). The Sisters' use of their experiences echos the research in which nurses who are parents can more ably problem-solve the crying of infants (Holden and Klingner 1988) and nurses who have had pain understand the pain experience better (Holm, Cohen, Dudas et al. 1989).

As mentioned in a previous section, the Sisters are attuned to meanings in all of their experiences. This enables them to draw on all sorts of experiences. Sr. Baxter talks about growing up within a sensitive family with a Granny who "had a great understanding of people" (Int. 2-3: 12). She says of her own understanding of people:

Sr. Baxter: [...]it comes from experience with people, not necessarily people in nursing. But in any experience you've had with people outside you can pick up a lot. (Int. 2-3: 11)

For the Sisters, the experience which they draw on for practice is not confined to specific, discrete situations, nor is it confined to nursing. Sr. Hanna puts it nicely when she says, "... my whole experience is my life" and "... just life is your experience" (Int. 8-3: 39).

With Experience Comes Confidence

While the Sisters have confidence which stems from their experience, confidence is not always there in new positions, or in untried situations. Sr. Inglis tells about experiencing her first year as a ward sister.

Sr. Inglis: [It was a v]ery traumatic year for me. Because I feel that I was as good a night sister as I could be. I tried to give support and the best care a night sister can give. And I had all that stripped away in the first year I came here. I really had to re-challenge myself as a person. I found that I wasn't as good a nurse as I thought I was. I wasn't as experienced as I thought I was. I didn't learn as quickly as I thought I was going to. And I didn't accept the change from a small hospital for a big one. So many things happened to me in that first year and it took me time to find my feet again. (Int. 9-3: 13)

In a new role, the Sister loses her feet; she does not know her way. It is only with time that she "finds her feet", and becomes sure of her footing. The amount of time it takes to become confident varies considerably. It is almost a year before Sr. Inglis feels "home and dry" as a ward sister. On the other hand, Sr. Jarvis gains confidence in her assessment of bladder clots through the course of a shift, although with time and subsequent experiences, her confidence deepens. It is not unusual for the Sisters to feel confident about some aspects of a situation and not as confident about others. They talked about coming to feel 'at home' in situations only when they were confident that they could handle the unexpected as well as what was routine.

Through experiences in practice, the Sisters come to have confidence in their own perceptions and practice. They trust their knowledge, and from this basis, act more flexibly, more confidently and with authority.

Sr. Baxter: [W]ith experience comes confidence. As you're a bit more assured of what you're exactly doing and what you're doing [it] with it becomes easier.... (Int. 2-3: 30)

Confidence as an outgrowth of experience leads the Sisters to notice and act differently. Sr. Ellis' sureness of knowledge comes into how she acts as a safety net when a nurse errs in changing a tracheostomy tube.

Sr. Ellis: [...] But, of course having changed lots of tracheostomy tubes I'm able to be more confident and to maybe press harder then they would.... (Int. 5-1: 17)

When the replacement tracheostomy tube would not go in with a gentle push and the staff nurse was panicking, Sr. Ellis knew just what pressure and placement of the tube would work to get it in. Having the "confidence of experience" (Int. 5-3: 26), the Sister understands the potential and limitations of the situation and understands her own capabilities to act. Being confident makes it easier to cope with unforeseen changes. Successfully handling traumatic 'first' experiences are a great boost to confidence, as Sr. Jarvis finds when she correctly assesses the bladder clot.

The Sisters use their feelings of confidence as a gauge of their experience, particularly in situations where there have been imperceptible changes over time.

After a rocky beginning, Sr. Inglis knows she is "home and dry" as a new ward sister when she feels confident in her experience.

Sr. Inglis: [...] [T]here was always apprehension coming on duty. And then one day I was no longer apprehensive and I realized that I was home. (Int. 9-3: 10)

Confidence also accompanies understanding one's own limitations in the job. Sr. Grant's confidence allows her to acknowledge that not all problems can be solved; some can only be contained (W7D4: 21). Through the self understanding and confidence which comes with experience, the Sisters recognize their own strengths and limitations. This may be one of the reasons why several of the Sisters say they get more satisfaction from nursing now than when they were students. Their experience and confidence allows them to get "closer to the patients" and "get more out of nursing" When the Sisters are confident, they feel at home in their jobs, in their ward situations. They have the comfort of dwelling in the situations they encounter.

Confidence Changes Understanding

Over time, the understanding of similar experiences changes. What was major, becomes minor; what was challenging and uncommon becomes commonplace and routine. The Sisters' confidence in their own abilities, know-how and practices, as well as their confident understanding of the patients and medical and ward practices all figure into such a change.

To Sr. Fraser, the care of a complex laryngectomy patient which was once new and challenging is now "routine" (Int. 6-3: 29). She knows what to do and what to expect. Sr. Grant describes two days, which I found as an observer to be complex and thought-provoking, to be "fairly typical" and "...not notable, in any way, really" (Int. 7-3: 1). They are routine for her. The days are:

Sr. Grant: Fairly typical of, of life here.

M.M.: Can you think of what makes them typical?

Sr. Grant: Ah.. similar sorts of problems. Problems that that have cropped up before, the same frustrations. Just the repetition of a pattern. (Int. 7-3: 2)

With experience, the Sisters' repertoire of skills and familiar situations increases. They see patterns in their own experiences and in their work situations. More of their knowledge becomes taken-for-granted, and different aspects of situations become salient. Their experiences of similar situations change.

As many patients undergo similar surgical procedures on the wards, the Sisters find that many situations become routine over time. They have few opportunities to say, "Oh I've not come across that before. Now what are we going to do about it" (Int. 10-3: 21). Usually, the routine nature of the surgery is overshadowed by the Sister's attention to the individual concerns of the people undergoing the procedures, and by the complexities of keeping the ward working in ever changing circumstances. Sometimes, however, the routine nature of the work is problematic. In Chapter 8, I discuss some ways in which the Sisters keep themselves noticing and attuned to their experiences in routine situations so that they keep their practice in question and do not become falsely confident.

Confidence then, is one of the indicators of the movement of experience. Confidence indicates a movement in understanding about oneself and one's capabilities. Confidence not only comes out of experience, it also helps the Sisters to be open to new experience. Confident in their abilities to see, hear and remember, the Sisters extend the range of what they notice; confident in their interpretations of situations, the Sisters try out new ways of interacting, and act with sureness; confident in themselves, the Sisters are not afraid to take risks and practise more flexibly. As we shall see in the following chapters, confidence features in the Sisters' practice and learning.

SUMMARY

Experience, I have argued, is more complex than it is usually portrayed in the research literature. Particularly in the experiential learning literature, experience is considered to be an entity which contains sense data; other research, including some phenomenological studies are primarily concerned with the meanings contained in experience. In contrast to the depiction of experience as a static, spatial entity from which meanings or data can be extracted, the examination of the Sisters' accounts and practices have revealed experience to be complex, continually changing and elusive. The Sisters' everyday experience was seen to be inextricably bound with their ongoing moment-by-moment practices.

On close examination of the interviews and field notes, two ways of understanding experience emerged. Experience was found to be a resource or entity, something which the person had or could gain. However, more importantly perhaps, it was also found to be an ongoing process - a process of experiencing. These two senses of experience were not found to be separate. Rather, they were found to be in continual interplay, with the experience in the sense of a resource growing out of, informing and being changed by the process of experiencing.

Experience takes a variety of forms in the Sisters' accounts and practices; I have depicted the range of forms by delineating three: "watershed", "resonant" and "bits and bobs". Watershed experiences are highly memorable, often first-time instances which are emotionally charged, specifically meaningful for the Sister and vividly told. They are specific situations in which the Sisters' understanding is considerably altered. They are similar to Benner's (1984) paradigm cases. Resonant experiences are less emotionally laden and often take place over a longer period of time. Patients who are memorable in specific contexts are often the subject. These experiences also may be the result of an accumulation of taken-for-granted experiences in which a gradual change in self understanding is realized. Typically, the narrative form of resonant experiences is less coherent; they need prompting to be recalled. Bits and bobs, forming by far the majority of experiences, happen all the time and are taken-for-granted. They concern the Sisters' ongoing practising, are often forgotten soon afterwards or are not considered to be important enough to talk about. As bits and bobs experiences may be kinesic experience, they may remain tacit and unsaid. They rarely come into the interviews and only then as a result of direct questioning.

When the interplay of experiences and experiencing was examined, experience was found to be grounded in concrete activities in time and place. The Sisters experience their practice within an historical situation; as the situation changes, so does their experience. In experience there is a continual interplay between the past and present, with a sense of expectation towards the future. There is a movement in understanding. In addition to the negation of previous understanding, in everyday taken-for-granted situations, understanding is extended, enriched and confirmed. Experience happens on a ground of meaning, in which situations and people matter to the Sisters. The Sisters are attuned, and pick up the meanings inherent in practice situations and in experiences outwith

the practice situation. Their care and involvement in the situation contribute to their picking up on meanings. Further experiences cast new light on old situations, bringing forth hitherto unidentified meanings. Experience is not compartmentalized by the Sisters; they draw on experience gained both outside and inside nursing. Confidence plays a special role. It seems to be one of the significant outgrowths of experience and features into the Sisters' ability to bring their experience into practice situations.

Experience can perhaps best be depicted as movement: a process which is interlinked with ongoing practising; an interplay between the experiences which the Sisters possess and the ongoing process of experiencing. In experiencing there is movement: in time, in understanding of practice and of oneself.

The problem in linking the interview and observational material to the notion of experience has already been raised, but such material is perhaps the best we can expect to gather on such an ephemeral phenomenon. Although experience is a personal, individual matter, it is also constituted in a social world and its public form is in the Sisters' practices. In the next chapter, I describe what the Sisters are doing in their everyday nursing practice. The central focus of their practice is helping the individual patient towards recovery, but in order to do that they make the ward work for all the patients. This focus in practice, on the individual patient in the context of the ward, parallels the Sisters' expression of their experience. They express a deep understanding of individuals in complex, and often difficult situations.

CHAPTER 6

SURGICAL NURSING PRACTICE

Sr. Jarvis: [.....] One thing I like about Surgical Unit is the fact that you bring patients in and you make them unwell and you make them better again. And that's always been something I think of as NURSING. We make these people unwell and then it's up to us to make them better again. (Int. 10-1: 15)

Patients play a pivotal role in the understanding of experience which emerges through an examination of the Sisters' everyday practice. Patients are the reason the Sisters practise nursing; they provide the situations within which the Sisters experience nursing. In the last chapter we saw something of the nature of the Sisters' experience and how it is linked to everyday practice. Clearly, experience consists of more than just isolated events: it is intertwined with ongoing, moment-by-moment everyday practice. This chapter then, is concerned with the Sisters' everyday nursing practice. The Sisters' primary goal is to help surgical patients towards recovery.⁵ However, nursing practice in a ward is a collective endeavour. It is led by the ward sister who determines the work to be done, organizes the nurses to provide care to patients and ensures that it is to a particular standard. In order to help individual patients towards recovery, the Ward Sisters must make the ward work for all.

The organization of the discussion in this chapter reflects the Sisters' experiences of the patients and the ward. In their accounts of experiences with patients, the Sisters usually set situations or concerns within the framework of the patients' stay on the ward. This frame is reflected in daily practices: at the change of shift handover reports, the nurses tell about the patients in relation to their stay. In keeping with this, the discussion about helping individual patients towards recovery is broadly structured around familiar landmarks in the patients' stay. In contrast, the discussion of the Sisters' practices which make the ward work is structured around the workflow of a single shift. This structure parallels the Sisters' experiences of the work of the ward which is expressed in the phrase, commonly heard amongst them, "Today's another day". Their practices and

⁵ Although the primary goal is to help patients towards recovery, not all patients recover. Helping patients to die peacefully is an important part of the Sisters' practice. It is underrepresented in this discussion as I have opted to focus on recovery.

experiences are complex. Contributing to this complexity is their focus on the care of each patient while making the ward work for all of the patients. Also contributing are the divergent temporal experiences: of the patients through their stay, and the work of the ward through a day.

The richness of the material in the interviews and field notes has provided a marvellous resource with which to create a vivid tapestry of the Sisters' practices. However, for the purposes of this thesis, a full depiction of their practices must remain secondary to the exploration of their experience. Therefore, in the discussion which follows, I hope to provide a glimpse of the Sisters' everyday practice and experience with patients in the ward. While only a glimpse, it will provide a context for the discussions about the process of practising and experiencing practice in the next chapters.

HELPING PATIENTS TOWARDS RECOVERY

The Sisters' practices are directly and indirectly geared towards helping patients who are admitted to the surgical wards to prepare for surgery and recover from it. What is striking about their practices is how active and complex they are. This perspective is missing from the research literature on recovery from surgery, perhaps because in most of these studies, the discussion concentrates on the patients' experience of recovery (cf. Webb 1984, 1986) and more commonly, on the patients' recovery process and specific interventions which influence it, such as information-giving, pain relief and exercise (cf. Hayward 1975, Wilson-Barnett and Fordham 1982, Johnson 1984). Wilson-Barnett (1988) suggests that these studies as a whole show that the type of intervention a nurse provides is "often a mixture of psychological support, physical coping skills, health education and practical advice". I would argue however, that the studies portray the nurse as peripheral to the patients' recovery. They show the patient recovering from surgery with minimal nursing input, and with few exceptions, the input appears mechanistic. In many studies, the nurse is virtually invisible. However, when the Sisters' experience is examined directly, a different view emerges. With their extensive repertoire of complex practices, the Sisters are seen to actively help patients through their surgical admission.

The Patients in Surgical Wards

Surgeons admit people to surgical wards because they are seen to have a problem which might benefit from surgical treatment. There are several routes to admission. The route taken has implications for the patients' needs, expectations and understanding about hospitalization and care, and in turn, for the Sisters' practices.

Patients may be admitted as "emergency admissions" on an "external waiting" day or night from Accident and Emergency or from another ward on an 'internal waiting' day. Patients also may be admitted to the ward from the outpatient clinic. These patients have been seen by the registrar or consultant and urgently need hospitalization. Patients in these two groups sometimes have complex problems which need to be diagnosed and "sorted out" or treated in hospital before surgical treatment is planned. Planned admissions, the third route, come from the consultants' waiting lists; patients are given a specific time and day to come in. Their course of treatment is more predictable and the patients are somewhat prepared for hospitalization. The last route of admission is through temporary transfer. Patients come from another surgical ward as "boarders" when the other ward is overflowing or because a ward is closing for the weekend or holidays. In the study wards, the decision to admit and discharge or transfer patients is always a medical decision but one which nurses influence. The nurses on a ward care for all patients on that ward as well as patients who are attached to the ward on an emergency or outpatient basis. They are also responsible for the discharge arrangements for patients who may be "boarded out" to other wards.

"Presenting Yourself": Creating the Possibility for Patients to Engage in a Trusting Relationship

The patients' arrival on the ward signals the beginning of their stay and the beginning of their relationship with the ward staff. The Sisters recognize this to be an important time, a time of first impressions, when patients will or will not begin to feel comfortable in the ward and to have confidence and trust in the nurses. The patients' experience during this time can set the tone for their entire hospital stay. The Sisters aim to make the patients' stay on the ward, a "smooth passage" from the time of their admission.

All of the Sisters ensure that new patients coming into the ward are acknowledged when they arrive, even though they might have to wait before being attended to. They recognize the vulnerability of patients at this time and the importance of first impressions.

Sr. Ellis: [...] You see them all sitting there, and they stare and they watch every movement that you make. And if they're seeing someone clomping up and down the corridor or [...] shouting, you can imagine what must be going through their minds: "Are these people going to be looking after me?" (Int. 5-1: 21)

The Sisters take particular care to introduce themselves to new patients.

Sr. Grant: I now see that there are times that are particularly important when you present yourself. And one of them is the first thirty seconds of your contact with the patient. (Int. 7-3: 17)

In presenting themselves, the Sisters are present with the patient. They tell the patient who they are and confirm the patient's name. Presenting "yourself" characterizes the nature of the relationship which the Sisters seek to develop - personal, yet purposeful; a relationship between individuals. During such encounters, the Sisters acknowledge both the patients and their concerns. Because of conflicting demands on their time, the Sisters have developed techniques which help them to engage the patient in a relationship in a very short period of time.

0955 - Sr. Inglis [...] goes to take some pillows to the left cubicle. Mr. Ball is in there, having just come in with his wife. He says he is nervous. She tells him that if he wasn't nervous she would be surprised. She jokes with him, "I won't bite and I don't scratch" and then she says that his wife could stay, that they were very busy and it would be a while before a nurse [comes] to admit him. (W9D4: 11)

Sr. Inglis describes her approach:

Sr. Inglis: You see I've got a little knack. And I'm not sure if it's good or not. I can pull somebody's leg, which means that I'm paying attention to them and I'm aware of them but it saves me from giving them any more time. To make him feel just that little bit of home, a quick joke. [...] When I explained I didn't have a nurse. I didn't want him

dismissed and him sitting there thinking, "My God!". So a quick joke and somehow it might just be peculiar to British people. I don't know cause we don't nurse many foreign people. It does seem to work with British people. (Int. 9-1: 18)

The Sisters, each in their own way, manage the tension between taking time for one patient and attending to all. They have developed practices which allow them to give what they can at the time to patients, to acknowledge them and their concerns, making them feel welcome and beginning to establish rapport. These are not just rote practices. Neither is it "emotional labour", inducing or suppressing feeling to sustain an outward countenance which produces the proper state of mind in others (Hochschild 1983). The Sisters become engaged with the patients. Their practices reflect their understanding that they are relating to patients as individual people like themselves, "... but *we're* individuals" (Int. 9-2: 31). And in questioning her practice, Sr. Inglis points to a flexibility of approach. In common with other Sisters, she acknowledges that what works for one patient may not work for others.

Establishing a climate of reciprocal trust (Thorne and Robinson 1988) at the time of admission is critical with patients who have had problems in previous admissions or who may have difficulty coping with the institutional milieu of the hospital. For example, Sr. Hanna helps to make "a smoother passage" for Linda, a 33 year old drug abuser, who is in for a laparoscopy and sterilization. Sr. Hanna knows Linda from previous admissions. The latest, the previous week, was marked by difficulty and mistrust, beginning with an altercation with the nurse who admitted her and culminating with Linda effecting her own discharge. When she arrives this time, Sr. Hanna greets her at the door and admits her herself. During the admission process, Linda expresses concerns that her medications are not all written up in a familiar way.⁶ Sr. Hanna explains the many medications, but then says, "But we will get these written up right" (W8D2-1: 20). She goes directly to the resident:

She asks him to write the meds up, the AZT and DF118, "in a more particular way as she expects it to be, with the exact times". He says, "That's fine" and strikes out the two orders and writes them differently. (W8D2-1: 20)

⁶ The medication orders and sheets are kept on a clipboard at the base of the patients' beds and are accessible to them.

By smoothly arranging the change in medication order and being present in a calm and cheering way, Sr. Hanna creates a non-threatening atmosphere for Linda. The effect on Linda is noticeable.

(Sr. Hanna's report to the late staff) "Linda [...] is like a different person this time :: She is most cooperative :: She is not keeping a constant record of our conversations. :: You would hardly recognize her as the same person." (W8D2-2: 14)

Hearing and attending to patients' particular concerns at this time creates a climate of trust and creates possibilities for a smooth passage in hospital. When the Sisters present themselves, they begin to engage the patient in a relationship which can positively influence their stay on the ward.

Helping People to Prepare for Surgery

In the preoperative period, the Sisters co-ordinate the various diagnostic and physical preparations for patients, tailoring them as needed to individuals. Adjusting preparations to suit the person range from negotiating with the anaesthetist to insert a nasogastric tube in theatre for a patient who is particularly anxious (W9D4: 10), to ensuring that the registrar marks the spot for an ileostomy stoma for a young man when he is wearing his usual trousers (W9D4: 7). Preoperatively, the Sisters play a major part in confirming, correcting and extending the patients' understanding of what will likely be happening during surgery and afterwards. When patients require emergency or unexpected surgery, this preparation can be complex. The Sister needs to assess and address the patient's specific needs for preparation, including information, usually in a fairly short period of time. The following extended example illustrates an intensive, complex, but not unusual process.

Usually patients with cancer of the larynx are diagnosed and "worked up" in the outpatient clinic and ear, nose and throat ward over a two week period prior to laryngectomy. Mr. Peet, a 73 year old man who came into the ward on Tuesday directly from being seen in clinic, has less than two days to prepare. It is Thursday before a four day holiday weekend which begins Friday. Mr. Peet had a direct laryngoscopy Wednesday and a large tumour was seen. The tumour was punctured on examination and he had an emergency tracheostomy. Two hours

before the following conversation takes place, the registrar discussed the surgery, scheduled for tomorrow, with Mr. Peet. As Sr. Ellis goes into the room, Mr. Peet is sitting up in his bed, with a nebuliser covering his trachy.

Sr. Ellis goes in to see Mr. Peet and Nurse Neale [a pupil nurse who is 'specialling' Mr. Peet] :: They are talking for a bit, and he is looking pretty agitated :: Sr. Ellis says something about him having the operation tomorrow and he writes "I don't want it" :: He looks frightened and says [mouthing as he can't speak], "No, no, no, I don't want it." [...]

Sr. Ellis: "They think it is the best thing for you." She continues but the conversation doesn't seem to be going anywhere.

Nurse Neale is on one side of the bed and Sr. Ellis is on the other. Sr. Ellis starts squatting down beside the bed so she is below him, but as he starts to protest about the operation, she gets closer to him, at eye level. As he protests a bit more, she backs away a bit, but she says softly "I think you're scared. I think that's it."

Then all of a sudden, it is as though there is an opening and she takes it :: She does most of the talking and he listens, looking ever more intently at her face as she talks, as though he is mesmerized, but taking it in :: She is looking directly at him the whole time.

Sr. Ellis: "She's a bossy boots type doctor :: She's new :: She's been upstairs :: but she's good :: So when they're new they try to :: :: ::

"Can I just go back to the beginning and go over it with you? :: My name is Fiona :: You've got cancer in your voice box :: That's making it hard to breathe :: [...] And I get quite breathless so I know a bit of what you're feeling when you're out of breath :: It gives you quite a fright :: ::

"So what happened yesterday is :: There's a growth on your voicebox :: right where the tube was :: The tumour was right there :: So they took a specimen :: ... Some people think that once the tumour is open or cut into it spreads :: People think once it's been tampered with, you have to do something about it ::

They don't know if that's true or old wives' tales ::
You think that's why they want to do it right away
[he nods]

"Usually people have time to prepare :: but you don't have the time :: They think you have a good chance of success :: It's as close to a cure :: I can't guarantee there is a cure, but they wouldn't do it if they didn't think there was a good chance of success :: There's a holiday tomorrow and it would cost twice as much to the health service to have it done. I mean, we're here anyway :: The doctors, on their own time are coming in :: They wouldn't do that unless they thought you had a good chance :: You'll be OK ::

"It will be the same sort of anaesthetic as before :: You made it through that one :: There will be some stitches here [pointing to her throat and to his] and you will have this tube in [pointing to the nasogastric tube] :: This hole in your throat is temporary, but they will make a permanent one:: You will get a breathing tube which will be permanent :: You could go home with it and eat with it :: You can't eat with this tube and if you went home you couldn't care for this one :: But you could go home with the other tube ::

"When the voice box is taken out a person doesn't breathe through your nose, but you're not breathing through it now :: and you won't be able to talk :: but you're not able to talk now :: you'll take the tube out and the hole will still be there :: It is like putting your teeth in in the morning :: There is no chance of cure or going home with this one. [referring to the tube he has in at present] You will be able to eat :: and you would get back to your normal life :: so at the moment :: this tube is in for life ::" *He's starting to look less angry and frightened and a bit more accepting.*

"Dr. Smith means well :: Don't put too much into how she said it :: She says things pretty straight :: We'll be telling you lots of things :: Do you normally have a wee nip? [He nods] How would you like me to put some down your tube? It might help to calm your nerves a bit. [He says vigorously, "NO"] :: The doctor will be coming in to put in your antibiotic :: your milk is due now [looking at Nurse Neale who says, "Yes, I'll do it"] :: Now, we'll put the sides up [putting the sides of the bed up] You can grab

one to get up or down :: If you have any questions at all or anything you want to ask us :: just ask :: I'll speak to your family when they come in :: Your family called, by the way, this morning :: I said you had had a good night ::" *He is looking much calmer by this time and has a look in his eye as though he is thankful to her.* (W5D2-1: 5-6)

In this 15 minute conversation, Sr. Ellis picks up that Mr. Peet's protests stem from feeling frightened; she supports the doctor's decision and skill, but not her approach; she talks about the kinds of things which other people facing laryngectomy have felt frightened about and through that process, addresses Mr. Peet's fears so that he comes to understand his situation. She sets the scene for more information and preparation. This conversation is a starting point for preparations with the dietitian, the speech therapist and the physiotherapist in which Sr. Ellis cues each about Mr. Peet's needs.

Although the conversation as verbally recorded is like a monologue, it is a dialogue as Sr. Ellis attends to Mr. Peet's non-verbal cues and responds to them. She notices the fine changes in his responses and adjusts her tone, physical stance, speaking and pacing to what she finds.

In the afternoon, Sr. Ellis takes the opportunity of Mr. Peet's cousin's visit to go through the preparation again. The character of this conversation indicates that Mr. Peet is coming to understand what is happening and to accept the need for it. Sr. Ellis begins to mobilize Mr. Peet's family to provide support through this disfiguring surgery. In the afternoon, Sr. Ellis brings a patient on the ward, who had a laryngectomy two weeks previously, in to meet Mr. Peet. This is a risk as each man's situation is so new to him, but the risk pays off, as both men indicate the following day (W5D2-2: 13).

In their conversations, Sr. Ellis links what is familiar to what is unknown. She links Mr. Peet's knowledge of having the temporary tube, with the tube to be put in; his knowledge of going through an anaesthetic with the anaesthetic to come. She does not minimize his concerns but uses his experiences to reduce some of his fear and anxiety. She also uses the experiences of others, in discussion and in person, to make the unfamiliar and frightening a little less so for both Mr. Peet and his family. As much as she can, Sr. Ellis arranges to have the time she needs with Mr. Peet, and to have others there at opportune times for him and his

family. Throughout the shift, Sr. Ellis stops at the door of the room to monitor the situation. As Sr. Ellis handles the complex and difficult task of helping Mr. Peet come to terms with his situation, while supporting Nurse Neale to give direct care, she fosters a climate of reciprocal trust and knowledgeable care.

During the preoperative period, the Sister gets to know a bit about the patient and his or her response to being in hospital. It often forms the baseline which the Sister uses for recognizing subtle changes in the person postoperatively, which indicate problems or progression in recovery. In emergency admissions, when this initial baseline is missing or the patient is in a stressed state, the Sisters have more difficulty knowing what to aim for and encourage. However, what they glean from their contacts with the patient and family preoperatively is drawn on as they care for the patient following the operation.

"He's Coming Along as Expected": Facilitating Postoperative Recovery

Metaphors used by the Sisters in discussing aspects of postoperative recovery express movement towards something: a journey, as in "he's on his way", or in the case of complications, a game or battle - "he's back to square one" or "he's had a setback". When faced with problems in recovery, the patient needs to "overcome hurdles", "get over the hump" or "get clear of the problems". When the recovery journey is going well, it is described as "smooth" or "progressing well" or "progressing as expected". From their experience of many patients in similar situations, the Sisters recognize "usual" patterns of recovery and link their understanding of a particular patient's progress to what might be expected. However it is impossible to extract from the Sisters' practice either rules for monitoring care or discrete phases of recovery. Their actual care of individual patients reveal a much more fluid and subtle yet active process than is described in textbook treatments of postoperative care. In the patients' postoperative stay in hospital, there are some notable ways in which the Sisters help them towards recovery.

Diligently Watching

Upon the patients' return from the operating theatre, the Sisters begin a period of closely monitoring individual aspects of the patients' physical status, including pulse, blood pressure, respirations, bleeding, pain, and in many cases, fluid

balance. In patients with more complex conditions, some of these physical parameters are measured mechanically. At the same time, the Sisters gather a total picture or impression of the patient in the bed, including the monitored signs and their significance. With experience, nurses become astute at picking up small changes in the patients' condition, what Benner (1984) terms "graded qualitative distinctions". The Sisters monitor each patient through the assigned nurses and focus selectively, "keeping a close eye on" patients whose conditions are less stable.

In the following example, Sr. Jarvis, with a first year student, diligently watches a patient newly back from surgery, picks up the "early warning signals" (Benner 1984) of postoperative bleeding and acts on them. In contrast to the similar situation discussed in Chapter 5, where she only responded once the patient was in severe pain and the bladder clot had formed, Sr. Jarvis attends to more subtle signs of bleeding and acts much earlier, preventing the need for further surgery.

Sr. Jarvis: [Mr. Scott] was a gentlemen who'd had a prostatectomy and he came back with bladder irrigation. Which was unusual because the consultant who'd operated normally uses [?] and Lasix and doesn't use irrigation. So I immediately thought that the reason for this must be that he'd had a large prostate resection. And his urine on return was really quite darkly haematuric.

So I said to the student who was looking after him that she had to be particularly careful at making sure that his irrigation always ran fully on, so that there was no chance of it clotting off. And to keep a very close eye on his urine output. That it was very haematuric, more so than we would like. His blood pressure and pulse on return were comparable with his pre-op. But I told her to make sure she would let me know if it started to fall.

About an hour later she told me that his blood pressure had dropped by about 30 mm diastolic and so I then immediately increased his IV fluids. And phoned the resident. [...] His blood pressure continued to drop and his urine still remained very haematuric so we started blood transfusions. (Int. 10-2: 21-23)

Following blood transfusions, the administration of atropine and about three hours of penile traction, the bleeding stopped and "everything then went according to plan" (Int. 10-2: 23).

In this situation, Sr. Jarvis was alerted to the potential for bleeding because of a variation in the surgeon's usual postoperative procedure and confirmed it by the quality of haematuria. "I wasn't happy with him from the minute he came back" (Int. 10-2: 24). On the Urology Ward, the nurses recognize a range of haematuria and its significance in relation to normal progression or difficulties in recovery. In assessing the patient, and the significance of the clinical signs, Sr. Jarvis includes how the patient says he feels, "he said he felt fine" and how he appears and when that changes "he initially looked fine [...] and just prior to the blood transfusion being started he looked to me quite pale. I noted he was a little bit clammy". By understanding how quickly a patient's condition can change when he is bleeding, she alerts the student to the importance of "diligently watching the patient from the minute they come back" (Int. 10-2: 24), and averts a more serious situation.

Recovery from the anaesthetic and the immediate effect of the operation takes from two to forty-eight hours for most patients. Barring complications, when the patient passes a turning point, "the hump", the Sisters consider them to be 'on their way to recovery'. Diligent watching continues until the Sisters sense the patients are over the hump.

"Helping Patients Over the Hump"

Surgery interrupts both the body's physiological integrity and the patient's feeling of wholeness. The Sisters pick up on the signs which indicate patients are moving over the humps of the early stages of recovery and feeling "themselves" again. These signs are simple, such as a change in focus of attention, interest in an event in the outside world, interest in appearance or even being ready to wear false teeth. Sometimes there is no specific sign, it is an overall sense. "[It's] a feeling that you can see [...] They just LOOK better" (Int. 2-2: 19-20). Building on that sense of the patients' readiness to move forward, the Sisters encourage recovery in small ways. They gradually involve patients in making more decisions about their care, help people to regain normal movement, and anticipate and guide patients and their families to understand new possibilities of action.

The Sisters' encouragement may be subtle. In the immediate phase of recovering from anaesthetic and operation, they give patients choices in such things as getting dressed, having a bath, or having pain medication before eating (for newly

post-op tonsillectomy patients), but do it in a voice and turn of phrase which implies no choice, "You'll have a bath now?" Later, the Sister gives the patient a real choice, again by phrasing and her use of voice.

At this time the Sisters' approach is much like a coach (manager) who is trying to mobilize the potential of the players (Benner 1984).

When Sr. Calder takes basins to a couple of men in the side ward she says, "Fingers", and indicates that Grant and John [who had surgery on their arms] are to do their finger exercises. [She stands facing] Grant: "Yes you can." *She and he do it together. She has her fingers up, showing him. He can see them "Push, push, push!" Slowly, with her face screwed up and looking like she is making effort too, she moves hers as he does. He is looking at her as he does it. "Good!! See - you CAN do it .. It's up to you. We can't do any more. We can do the surgery :: You have to take it from here."* (W3D2: 6)

Sr. Calder suggests to John that he get a bath and move his arm in it. He tries it, skeptically, and is delighted with the way in which he is able to move his arm in the water. He begins to re-learn his taken-for-granted, normal range of motion. In another situation, Sr. Fraser gives tablets rather than syrup to a quinsy patient who is reluctant to swallow in order to assess his capacity for swallowing as well as to help him exercise his throat muscles (W6D4: 11). The Sisters notice the patients' potential for recovery, understand what is needed to regain normal action, and when it can occur. They help patients to recognize and re-engage their normal bodily understanding through specific exercises as well as through simple everyday activities.

Sometimes the patient loses the will for recovery, no longer seeing a purpose for recovery or a possibility of regaining health. In these situations, the Sisters talk about their active role in "pushing" the patient or in some cases, "battling for the patient". The Sisters see possibilities which patients do not see and actively attempt to engage patients in seeing these possibilities for themselves.

Sr. Inglis: There was an [...] old man who'd lost his wife this year. He admitted that he had nothing to go home for. And we had a battle to get him to Convalescent Hospital. He was a dear old soul. You could have done what you liked with him, he wouldn't have put up any effort. So you needed to instil in

him, the will to live if you like. The reason for going home.
[...]

Well he was very depressed one day and he didn't want to eat. [...] You could get him up out of the chair and do what you LIKED with him. [...] He wouldn't put up any resistance. But you knew it was just being a puppet if you like. And one day I said, "You're miserable and depressed aren't you?" He said, "Yes." And I said, "Now I know you've lost your wife. Do you feel you've nothing to go home to, nothing to live for." And that was just it. And once we'd established that, once someone had been honest with him and said, "Well I can understand that, but you can't throw in the towel can you?"

He'd a daughter, a son who were very loving. His daughter, [...] came in EVERY single day. Brought the grandchildren in. So we had to use that as a stepping stone for him. And say, "Come on. You know they're coming every day. Don't you think you should try just a little harder? Just even today." And that's how slowly we got him there. (Int. 9-2: 12)

Sr. Inglis captures what is preventing this man from becoming reintegrated with his world and helps to harness and mobilize his will to live through. Drawing on what they know of patient preoperatively and from the patient's family, the Sisters intervene with a timing and pacing which maintains a productive tension between pushing the patient and "going with him" in his own time. Just as Sr. Ellis assesses the potential support which Mr. Peet's family can give as she draws them into the preoperative preparations, so the other Sisters carefully mobilize the family to help patients towards recovery.

Bringing Patients "Into the Body of the Kirk": Promoting Recovery Through a Place in the Ward

The Sisters use space in their wards to promote patient's physical recovery and to help patients become re-engaged in a social milieu. Patients are placed in particular beds to facilitate their observation and care by the nurses, to promote their socializing with other patients, for ease of walking to the toilet, for control of infection, and other reasons. On the Nightingale wards, ill patients are usually at the "head" of the ward, near the nursing station for ease of observation and attention. As they recover, patients are moved farther "down" the ward, or "out" into a side ward. Sr. Aitkin discusses her plans to move Mrs. Jones, a 72 year old

woman with an above-knee amputation, who is reluctant to take an interest in her food and is fearful of going to the rehabilitation hospital.

"[I think we will] bring her into the 'body of the kirk' for a couple of reasons... So she is not so near the nursing station :: She might feel not quite so sick. When they're down this way, they talk more. She'll see others in situations like her own. Mrs. Harper [a lady with an above the knee amputation] will talk with her. She will see how well Mrs. Harper is doing. Mrs. Harper has been to Rehabilitation Hospital and Mrs. Jones will be going there tomorrow. She will see that Mrs. Harper has to have another leg off, so she won't feel so sorry for herself. She will see the leg Mrs. Harper has. It will give Mrs. Harper something to do to keep her mind off her own problems, and off thinking about her own operation". (W1D3: 1)

The Sisters recognize the support and example which other patients provide and set up situations for that to happen. They recognize the meaning of placement in the ward for the patient and their family and incorporate it into their care. After clearing it with the bacteriologist, Sr. Inglis brings a patient with a severe *Clostridium Welchii* (gas gangrene) infection who had been nursed in the cubicle for ten days out into the ward. The move had a marked effect on his depression. "Slowly over that period he began to take notice and perked up" (Int. 9-2: 5). It was also a good prognostic sign for his wife. "I think she felt a sense of relief somehow that maybe he was off the danger list by doing that" (Int. 9-2: 6).

The Sisters understand the meanings which being in certain places have for patients and their families at various times in the recovery process. A place in the ward can both indicate and promote recovery. Being in certain places is also of particular importance as patients become ready for discharge, as we shall see shortly.

"Getting it Right for You": Addressing Common Problems Individually

Although postoperative pain and wounds have been the focus of much nursing research, the meaning of pain and wounds for patients is not readily discernible in much of the literature (cf. Boore, Champion and Ferguson 1987, Seers 1987, Fordham 1988, Ames and Kneisl 1988). This would be noteworthy in itself given the self-evident importance of understanding pain and wounds from the

perspective of the patient. It takes on added significance here, as will be apparent, since the meaning of pain and wounds for individual patients and their recovery figure highly in the Sisters' practices of pain control and wound care.

In familiar situations, the Sisters use the amount of pain a patient is experiencing as an indicator of recovery. A certain amount of pain can be expected at some points; if the patient experiences more, it indicates actual or potential problems, requiring nursing action. Sr. Aitkin persists in getting the resident to bivalve a cast on Mrs. Harper two hours after amputation, on the basis of the patient's complaints of pain which were out of step with the amount of pain medication she had received. The bivalving released the pressure from a slipped drain and poorly applied dressing. Sr. Aitkin acted on intuition: "I've known her for a long time. (full stop) She had pain" (W1D5: 11). Understanding the meaning of pain is often difficult, particularly when the Sister does not know the patient's normal response to pain, or when the operation is a new or unfamiliar one. The Sisters talk about trying to understand whether the pain might be "in the operation", or whether it is "in the patient" (W8D2-1: 10). That is, they try to understand the nature of pain that can be expected: including how much pain, where it is located, what kind of pain it is, what it feels like and when it occurs.

The Sisters want the patients' pain to be controlled in a way that suits the patient. On one ward, where many patients have chronic pain and are on large doses of morphine, the consultant joked, "Good - now Sister's back all the patients will be awake" (W1D1: 11). The Sisters fine tune the amounts of medication and administration times for each patient, so that they are awake, able to move when they need to and ready for meals at mealtimes. The Sisters aim for an optimal analgesic cover, so patients are neither over nor undermedicated. Methods such as pain charts are sometimes used to help patients communicate clearly with the nurses about intractable pain so their medication can be adjusted accordingly.

The Sisters recognize that giving analgesia in an anticipatory way might not be the best for everyone in all situations. The goal is to "keep on top" of the pain in an appropriate way. They discriminate between when more analgesia is needed or when another approach is more helpful. When a nervous first year student says to Sr. Hanna that the woman to whom she was giving her first day post-op bath needs more analgesia, Sr. Hanna considers the request in its context. She looks at the patient, confirms that her analgesia should still be covering her, talks calmly

to both the student and the patient, telling the patient what the student will be doing and suggests that the bath should help to alleviate the pain. When the patient asks what she could do to relax, Sr. Hanna suggests, smiling, "Talk about anything but your operation. Nurse, keep her away from that topic." With that, both student and patient appear less anxious; the student proceeds with the bath and the patient declines pain medication until two hours later (W8D2-1: 7).

Characteristically, the Sisters remain attuned to the importance and significance to the patient of what is routine to the nurse. Removing sutures is a good example. As Sr. Dunn takes sutures out of Mr. Law's long thoracotomy wound, she attends to his anxiety, asks whether he has experienced this before, gives him an idea how long it will take, distracts him by asking about his plans for home and works quickly. She repeatedly glances at his face during the procedure and asks him whether he has pain, when she is about half way through (about 45 seconds into the procedure). While she is cleaning it she says, "That's all out. The wound looks fine. You can have plenty of showers on it. It's well healed." Anticipating what he might be thinking, she states it. "People don't believe it that you can go home like this seven days after a big operation like this." Mr. Law nods and looks relieved (W4D2-1: 3). By giving him specifics about what she is doing, in her timing and sureness of touch she completes a very routine procedure, but in a way that acknowledges its uniqueness for that patient. Throughout the process, she is attuned to how the patient is responding to the procedure, and modifies her movements accordingly.

The Sisters have become skilled in adapting wound dressing materials to individual patients and their wounds. The Sister develops her technique uniquely with each patient in response to their specific needs.

Sr. Grant: Well the technique for doing the dressing, for instance.
how to get the patient to hold his legs that it's most comfortable.

It's interesting. If you do the dressing one day, the patient says, "Now Mary did this and Mary did that and if you do this it's easier." It's not generally something that's written down because it's too inconsequential. It's just something that has developed between the patient and the nurse that usually does that dressing. (Int. 7-2: 16)

Rather than being inconsequential, these could be considered skilled practices, tailored to the needs of individual patients which develop through shared experiences of patients and nurses. When patients have repeated dressing or tube changes, this practised skill, sureness of touch and timing is critical. It has considerable impact on the patients' confidence, pain and hope.

The Ward Sisters routinely monitor slow-to-heal or chronic wounds for changes, providing continuity for the patients, their relatives, other nurses and the doctors. They do not merely observe the physical changes in the wound. The Sisters come to understand the meaning of what the wound smells like and looks like and feels like for the patient and their family. They recognize the importance of this wound and find out how the patient and the family are coping. The wound is not merely "a disruption of the integrity and function of tissues in the body" (Wilson-Barnett and Batehup 1988), but has meaning to the person and his family. Indeed, for some patients, the wound can become the centre of their existence. The Sisters incorporate their understanding of such meaning into their caring practices.

Keeping Patients, Families and Health Workers in Synchrony

Sometimes during a patient's hospitalization the expectations, goals and understandings among patients, their families, doctors and nurses are in conflict or get out of step. Nurses and doctors can get out of synchrony about the plans for the patients' care. This occurrence, a commonplace one, will be discussed in the next section on making the ward work. Less frequently but as importantly, families of patients can get out of synchrony with the doctors and nurses about problems which the patients have and how the health care workers are addressing them.

When the patient's prognosis is clear and optimistic, keeping families up to date is straightforward. When the prognosis is changing or is not good (or both), the task is more difficult. Staff's and families' notions of time, of how quickly change can be expected to occur differ. "Things sometimes happen too fast for families or happen too slowly" (Int. 7-2: 3). This is well illustrated in the situation of Mr. Green, a man who had an amputation and subsequently suffered a stroke, an infarct and an embolus in the other leg. After the initial amputation, the nurses and the family discussed "the likely course of events after his operation".

Sr. Grant: Then all these insults occurred. And that no longer became an appropriate plan at all. And yet family clung on to this, this plan. And his wife said to me about two days after his [?] stroke, "You said that on his third, fourth day he would be out of bed. Why is he not out of bed?" I said, "Well things have changed and he's no longer able to support his weight. If we sat him in a chair he couldn't support his upper half. He'd just flop over. He's much more comfortable in bed." "What is the physiotherapist doing with him? You said that he would be given exercises to encourage him to straighten his knee and it's not happening. Why is that?" So there was no grasp that things had changed.

And it was... quite difficult to be quite open with them and yet not make them lose all their hope. (Int. 7-2: 4)

To get the family in synchrony the Sister has to find a balance, instilling and maintaining hope for recovery, yet not leading them towards unrealistic expectations. She helps the family towards a reasonable outlook for this patient, so they can help him in a new, but realistic way.

In a similar situation, Sr. Grant shows the family of a man who has suffered a stroke how they can best help when they come to visit.

Sr. Grant: [H]e showed neglect of his left hand side and he had a hemiopia and wouldn't attend to you at all if you stood on his left. And yet they came in and they'd sit on his left hand side and speak to him and when he didn't respond they started to raise their voices and shout as though he just wasn't hearing. (Int. 7-1: 15)

Sr. Grant repeatedly explains to the patient's wife and daughter where to stand so he can perceive them, to no avail. However, a granddaughter is more perceptive and helps her grandmother to understand.

Sr. Grant: "Look what happens when I come round here. Granddad looks at me and will answer me. But if I go round here he just ignores me." So she did it for me. (Int. 7-1: 17)

Keeping the family in synchrony includes recognizing the family's strengths and weaknesses and working with them to help the patient towards recovery or a peaceful death. One of the most difficult aspects of keeping the family in synchrony when the patient's prognosis is not good is "striking a balance between being dreadfully pessimistic with [them] and being hopelessly unrealistic" (Int. 7-

1: 17). Working to strike the balance implies an appreciation of the meaning of the illness experience for the patient and family, as well as understanding the possibilities inherent in the situation.

Being Ready to Go: Helping Patients to Prepare for Discharge

On the study wards, patients are discharged when their medical condition warrants it, and when the Ward Sisters think they are ready to go. Being ready implies more than just physical readiness. The patient must feel ready, confident enough in themselves that they will be able to manage. However, they should not be kept longer, so they "lose the impetus to really get back to independent living" (Int. 7-3: 3). The Sisters have a clear understanding of what they can offer the patients in the ward, and what has to be offered elsewhere. Although pressures on beds means they sometimes feel that they discharge patients too soon, without sure supports at home, they practise from a sense of timing about the safe limits for discharge.

One way in which the Sisters help patients to become ready for discharge is to "plant seeds", suggesting to the patient when he may be going home before the actual time or day of discharge. On hearing it stated, many patients turn the possibility over in their mind, begin to make arrangements and are feeling ready to go when they are discharged. Planting seeds is not only a matter of telling people what they might expect. It includes helping them experience, in a time-limited and safe way, that they can manage outside the hospital. The Sisters arrange for some patients to go home for the weekend, "to find their feet in the outside world" (Int. 1-1: 6).

In the following example, Sister Aitkin helps a young woman who has had an ileostomy created get out into normal society and rediscover her self confidence.

Sr. Aitkin: [...] We had a pub near the hospital. [...] [Betty] was a young girl needing to get back into society but was a little apprehensive about going out. And I said would you like to go out for a drink and she thought this was quite good but, "Oh I can't!" she said. "I- I- I've got nothing to wear." And I said, "We'll get your Mum to bring some clothes in." And the interesting thing was that a pair of jeans [...] came in. She spent all day doing her hair. She was a very pretty girl. [...]

And we went across to this pub and she had these very tight jeans on and we could not see her ileostomy bag. She couldn't believe that she could be dressed and people didn't know that she had an ileostomy. And she said, "Dad gave me some money to get you a drink." I said, "Fine, I'll have a such and such." And she said, "But you go up to the bar and get it." "No no," I said, "You're treating me." I said, "You go up to the bar." But she said, "They'll all know." And I said, "What do you mean they'll all know?" She said, "That I've got a bag on." And I said, "Why not go, you can't see it." She said, "I know I know but I'm still, you know." I wouldn't go and get the drink and I said, "They're all going to look at you cause you're a very pretty girl," I said, "Not because of your ileostomy bag."

And she went up to the bar, she bought the drinks and that was fine. She was so thrilled with herself that she'd actually achieved a small hurdle by going up. But nobody was aware that she had a ileostomy at all. And I felt that we'd done quite well there because she'd treated me to a drink. She was able to talk about other things. We didn't talk about hospital all night at all. (Int. 1-1: 5-6)

Going to the pub allows Betty to try a normal social situation with support from someone she knows and trusts. Betty has had time to prepare herself and the tight jeans indicated a readiness, which Sr. Aitkin picks up on, pushing her to go to the bar to get the drinks. Through such ventures as this one, the Sisters help patients who have undergone major changes to regain confidence in themselves before being discharged from hospital. They make what was once familiar but is now strange, familiar and normal again.

This interplay between patients' physical recovery and feeling of readiness to go home is assessed and promoted in different ways. Following ear surgery, on the day before discharge, the patients' first hair wash is done by a staff nurse or sister. Sr. Fraser uses this opportunity to assess how the patient is and how the wound is healing, give information about how to care for the wound and what to expect at home (W6D2: 15).

Through practices such as these, the Sisters help patients in their passage through the ward. The practices which I have described thus far may seem nonetheless, somewhat devoid of background. The focus has been on the Sisters and the patients, with little account taken of what else was going on at the time. Although in the everyday practice of the Sisters, the patient and the Sister are never isolated

from the ongoing stream of the ward, such a focus is not out of place. When the Sisters are with individual patients, their concentration is centred on them. (Indeed, they recognize this themselves (Int. 4-2: 47)). However, the only way in which they can fully gear care to individual patients, and to give them concentrated attention while ensuring the care for all, is through their practices of making the ward work.

MAKING THE WARD WORK

In charge of a ward of 20 to 36 beds,⁷ the Ward Sisters are responsible for ensuring the care of patients, managing the staff and material resources of the ward and contributing to the education of students. They are the co-ordinators and decision-makers at the centre of a complex, ever-changing network of communications, people and services (Runciman 1983). They make their wards work in a way which enables them to achieve their goal of helping individual patients towards recovery (or to die peacefully).

There is an immediacy to their workday and work concerns which stems, in great part, from the work of caring for surgical patients. "Today's another day", a phrase which I heard several of the Sisters use, reveals that immediacy. Although their goals for individual patients and the ward transcend the time frame of a day, the Sisters make the ward work while they are on the ward, one day at a time. In this vein, the following discussion is largely organized around the flow of a day.

Allocating the Work of the Ward: Matching Nurses and Patients

To accomplish the work of caring for all patients so that each may be helped towards recovery, the Ward Sisters need to maximize the potential of their staff. They do this by creating complementary work groups, assigning the nurses to patients in such a way that patients can receive the care they need and cueing nurses to the individual needs of patients.

⁷ The term 'beds' is used here because with admissions, discharges, day surgery patients, emergency and outpatients, there may be more patients than beds at any one time.

The Nursing Staff

The Ward Sister is given a complement of qualified staff which is augmented by learners.⁸ Qualified staff include ward sisters, staff nurses and on some wards, enrolled nurses. On most wards there is only one ward sister; on four of the study wards there are two. The staff are deployed by the sister according to the anticipated work flow on the early and the late shifts.⁹ On some wards the staff nurses rotate onto nights (an internal rotation). While on a several week night rotation, the staff nurse is removed from the "Off Duty", or work hour sheet. She reports, as do the other night staff, to the night sisters. The Sisters usually do not know who is coming onto the night shift. This separation of responsibility for staffing the ward on days and nights sets up particular issues of continuity in patient care which are discussed later.

In one of the study hospitals, learner nurses make up a large proportion of the nursing work-force on the surgical wards. Learner nurses include students who are studying towards their registration in General Nursing, Mental Handicap Nursing or Mental Nursing (first level nurses) and pupils who are studying to become second level or enrolled nurses. The learner nurses in both study hospitals are from one of two colleges of nursing and midwifery and one university nursing programme. The colleges control the allocation of students to the wards, so their numbers fluctuate. As the wards depend upon them for staffing purposes, when the numbers are low, the ward can be short staffed. Most of the wards in this study are used for the initial surgical nursing experience in the students' first year (13 weeks) and for the senior management experience (8-9 weeks). Some of the wards are used for surgical specialty experience or for "unallocated" periods (4-5 weeks). Three wards in the study, orthopaedics and the two ear, nose and throat surgery wards, are sites for the post-basic course in their specialty and often have a post-basic student on the ward for several weeks at a time.

⁸ For example, on a 21 bed general surgery ward, the staff complement is 1 Ward Sister, 5 staff nurses and one auxiliary. Of the staff nurses, one is on rotation to nights and one is usually on days off/annual leave. The ward has from 4 to 7 students, usually at least 5. It is unusual for the ward to have a third year student; there are normally 2 second years (in their first surgical rotation) and 3 first years. The number of staff assigned to each shift varies with the availability of students but usual staffing is four nurses on the early shift and three on the late. One of the nurses on each shift is a staff nurse or the Ward Sister. In addition, there may be a nursing assistant or orderly.

⁹ The early shift runs from 7:30 A.M. to 3:45 P.M. and the late shift from 1:00 P.M. to 9:00 P.M. Night staff are on the ward from 8:30 P.M. until 8:00 the next morning.

Part-time housekeepers or ward clerkess' perform clerical functions such as ordering supplies and equipment, making up patients' charts, and doing some of the paper work which accompanies patient admission and discharge. As with almost all the positions in the ward, when the ward clerkess is on maternity, illness or annual leave (the equivalent of vacation and statutory holidays) she is not replaced and the workload falls on the Ward Sister. Nursing assistants and orderlies (on the male wards) complete the complement of untrained staff. On many of the wards there is only one auxiliary worker. As an experienced, long-term worker, the auxiliary is often a valuable, knowledgeable resource to the ward. A domestic worker on each ward assists with preparing the meals and the ward cleaning, but reports to a housekeeping or cleansing department. The Ward Sister generally makes sure there is a good working relationship with this person as the nursing staff has to pick up aspects of their workload when he or she is absent.

Aside from the Sister and the auxiliary workers (and on some wards, the enrolled nurses), the work-force is inexperienced and transient. Most qualified nurses remain on the ward for only a year or so before moving to other nursing fields such as district nursing, intensive care or midwifery. To have a staff nurse on the ward for more than two years is quite a rarity. Nurses are expected to move on to "broaden their horizons" in courses or in other nursing fields. For learners and some staff nurses, work on a particular ward may be a necessary interlude in their plans to complete a course or get enough experience to be able to work in a different specialty. They are "just passing through" (Melia 1987). Several of the study wards have only very junior staff nurses; the Ward Sister is the only experienced nurse on the ward. Such a work-force has considerable impact on the work of the Ward Sister.

Creating Complementary Work Groups

Anticipating the workload and the capacity of the available nurses, the Ward Sisters arrange the "off duty" (the allocation of nurses to each of the 14 early and late shifts in a week) to allow for "adequate cover". They take into consideration the strengths or weaknesses of the nurses who will be working together. For instance, Sr. Grant assigns a group of nurses who may have difficulty getting through the work, and who may not be too observant of patient needs on a day in which the workload is less demanding. She schedules herself to work the

following shift, so she catches needs and problems which may have been left unaddressed (W7D5: 1). Often the Ward Sister assigns herself to work with the most inexperienced nurses so she can support them with her experience, and provide a level of safety not possible otherwise. In scheduling the nurses' off duty, the Ward Sisters attempt to maximize the potential of the staff to meet the needs of the patients.

Allocating the Work

In allocating the work of the ward, the Sisters aim to make the best use of resources, meeting the needs of patients for individualized care and the needs of nurses for a challenging but not overwhelming work assignment. They strive for flexibility yet suitability. The Sisters consider the patient assignment to be one of the more important jobs they do.

Sr. Grant: I make up an allocation of staff to patients and that's one of the most important parts of the day because if you do that well, your morning will run smoothly, your students will learn; your patients will be well cared for. You do it badly then everything falls apart. (Int. 7-1: 9-10)

Although all of the Sisters make a form of patient assignment, the shape is unique to each ward. Patient length of stay, the physical layout of the ward and patient procedures figure highly into the particular form. On vascular surgery wards where few patients go to theatre each day and patients stay from a week to a year, nurses are assigned to specific patients on the early shifts. On other wards, where patient turnover is quicker and more patients are going to theatre, the location of patients is a greater factor in their assignment. Often a more senior nurse and a junior nurse will be assigned a group of patients, for example, "You've got rooms 1-6", or "You take the right side". As patients are placed in particular rooms or beds according to their nursing care needs and their stage of recovery, what sounds like a physical space assignment is actually assignment of patients. This mode of assignment is also common on the late shift when there are fewer nurses.

Continuity for patients is provided in ways which suit the patients and their environment. In the gynaecology ward, a team of nurses is assigned to care for patients of each team of surgeons who operate on particular days. The nurses continue to care for these patients for up to a week of their stay. On the Ear, Nose

and Throat wards, where between 10 and 20 patients go to theatre each day, the patient assignment is linked to the theatre list.¹⁰ Two or three nurses are assigned to "pre-op and post-op". Although it could be construed as task allocation, two nurses prepare the patients for theatre, take them to theatre and care for them following their procedure. Usually the nurses assigned to pre and post-op are a staff or enrolled nurse and a learner, which allows for supported learning while accomplishing the work. There is continuity of care for the patients, and an efficiency of workflow that allows fewer nurses to manage a larger workload.

Frequently, the needed nurses are not there or the workload increases unexpectedly. Flexibility becomes the byword. One Sister describes the assignments she makes in these situations as we "all pitch in". For example, on one weekday early shift the Sister, two first year students and an auxiliary (in the morning) are on to care for 20 patients, most of whom are on bedrest.

Sr. Aitkin: So you just do what you have to do. I could have been criticized maybe for the WAY that I ran the ward last Friday. I used the Resident to take patients for their [invasive procedures], to a different department, and to go and collect them for me, because.. I couldn't go. I couldn't leave the ward and a first year couldn't go. And so the doctor did it.

One of the sickest ladies I had in the ward at that time, I had the auxiliary look after because I knew that she would do it the way I wanted it done; that she would report to me anyway if there was any change [...] I knew the first year would be too frightened to look after this particular lady. And the lady didn't come to any harm. She was very well cared for and everything was fine.

But I could have been criticized for doing that. But to me that was the only way I could manage the ward that morning. We all had a super morning. Everybody worked very hard and it all went very well. But it wasn't right. [laugh] (Int. 1-2: 29)

In one of the study hospitals, the Sisters experience many shifts such as this one. They are able to manage in such situations by virtue of their experience: knowing the capacity and strengths of their staff, anticipating the workload and flow of the

¹⁰ A number of these may be "day cases", people who are admitted in the morning, have their procedure, recover on the ward and are discharged home in the evening.

work through the shift, and knowing how to maximize the efforts of all their staff. However, in these circumstances, junior nurses take on more responsibility, with less supervision. They cope "beyond what they should be expected to do" (W2D1: 1).

Preparing Nurses to Care for Individuals

It is usual practice on the study wards for a nurse to begin on a ward and to take a fair share of the workload on that first shift. Hence, the Ward Sisters become adept at introducing a new student or permanent staff member to the ward in a very short period of time in the midst of the regular ward demands. A stark example of this is when Sr. Grant orientates a new, first year student to the ward in a period of five minutes before the late shift starts and while a moribund patient is admitted to the ward from Accident and Emergency. She is shown the most salient things in the ward so she can begin to function quickly and safely. Her questions about making off duty requests, her learning objectives, who will support her and assess her performance are anticipated and addressed immediately (W7D2-1: 2-3). Sr. Grant pairs her with a staff nurse for the next two shifts, giving them patients who offer opportunities to learn some basic care practices on the ward. The staff nurse will continue to serve as a source of support and continuity for the learner throughout her placement on the ward.

But perhaps the most important way in which the Ward Sisters prepare the nurses for the care of the patients and for managing their workload is through guidance at the handover report and the patient assignment. At the change of shift, the nurse in charge of the previous shift tells the nurse in charge of the oncoming shift (and others who may be present) about the patients, organizational arrangements and incidents which have happened on the shift. Handover reports are not only used to pass information on from one shift to another. They are also opportunities for the nurses to explore some patient problems and come up with ways of managing them, to catch up on organizational or policy changes, and to relate how particular patient or organizational problems were solved. At this time, the Sisters give the patient assignment, telling about each patient. They pass on expectations about standards of care and help the learners and junior staff nurses to extend their knowledge of patients. Handovers are a key time in which the organizational culture of nursing on the ward is articulated and transmitted (Lelean 1973). The Sisters cue the staff

about what kind of information is valuable and worth passing on, and what comprises surgical nursing practice.

When Sr. Aitkin gives nurses their assignments they hear about the patient as a person. With occasional reference to the patient's kardex, she often gives a short history of the patient's condition at home and in the hospital, gives some relevant facts about the condition or operation, the current goals for the patient's care and some specific things which the nurse must watch for, or attend to.

Mrs. Muir :: 83 :: had a phenol sympathectomy :: She has been with us for some time :: She has a pre-gangrenous right foot :: She is a widow :: She has a grand niece who shows warm concern for her :: She is mentally alert from the waist up :: Her main concern is her cat :: We are aiming to get her to be with her cat :: get her to Rehabilitation Hospital :: We've even discussed Part 4 Accommodation :: She's fairly happy :: It is interesting, when I sat down to talk to her about her rehabilitation, she asked for tissue but she didn't use it :: She had a phenol on her other leg 11 years ago, and she asked "Why it isn't working with it this time?" I said, "You're 11 years older." :: She needs a lot of encouragement :: She's a great churchgoer :: I watched her neighbour yesterday, organizing her bedside :: She can have a bath if she wants to get out of bed :: Her toe is blackened :: It may drop off :: The phenol has helped :: She walks with a zimmer :: She veers to the left while she is walking with people :: She may have had a wee stroke :: She can sit out of bed :: (W1D2-2: 5)

By telling about the patient as an active person in a family with interests and concerns, Sr. Aitkin conveys the view that patients are people whose time in hospital is an interlude from their normal life. She alerts the student to some of Mrs. Muir's interests which could serve as the topic of conversation and a point upon which to establish a relationship. She also interprets the symptoms which Mrs. Muir is experiencing and alerts the nurse to potential changes and their meaning. When time permits, Sr. Aitkin may take up to an hour to give this type of report on each patient to all the nurses, but feels it is worthwhile because:

Sr. Aitkin: [...] these people are in for so long, it's very important to try and make the report interesting and make them think about the cat. (Int. 1-3: 18)

Although other Sisters may not take the same amount of time in report, the flavour of their assignments is the same. With differing amount of detail, depending upon the experience of the nurses, the Sisters point out specific, salient aspects of care. The Sisters place the nurses' work in a context of the patient's overall recovery process and help the nurses to understand the reasons for their actions. During the handover and patient assignment, the Sisters not only allocate the workload, but also help the nurses to learn about the patients' conditions and operations and most importantly, encourage them to think about their patients as people.

Planning the Care: Having a Clear Agenda

Organizing the workflow of the ward is dependent upon planning the nursing care for individual patients, which in turn is intertwined with the medical plans and practices. Planning for care of the patient is the focus of the medical rounds which happen at least once daily.

To contribute to those rounds and to plan for the workflow of patient care, the Ward Sister makes an assessment of each patient early in the shift. Although she receives information on each patient at the handover report, the Ward Sister needs to "see" the patients for herself before making rounds with the doctors. In the early part of the shift and at the handover report, the Ward Sister gets an overview of the ward, a sense of what has been happening and how the staff on the previous shift have been managing.

The Sisters' initial round to the patient is usually combined with at least one other activity. One Ward Sister receives the handover report from the night shift nurse at the patient's bedside. She is able to ask specific questions, say, "Good morning" to the patient, see how they look and find out from them how they are feeling. Another gives out the breakfasts:

She gives different bowls for cereal, depending on how agile the person is likely to be with the spoon. She does not spend a lot of time with each patient and no more than a look at the patients who have come in overnight and are fasting [for theatre], but I get the feeling she is doing her first of the morning assessment. She [checks out their circulation and range of motion], she finds out who is brighter or

sicker than the day before, she finds out who is hungry today but wasn't yesterday, she finds out how easy or hard some people are to rouse; she finds out if [a long-term depressed patient] is cheerful or not. (W3D4: 1)

Assessing patients at this time is not a unitary activity, nor purely one of observation. The Sisters interact with the patients, suggesting activity for the day, and hear patient's questions and concerns about future plans. They see how the nurses are beginning to organize their own work. From this early round, the Sisters bring to the rounds with the doctors, specific concerns about each patient, their overall impression of the patients and how the nurses are carrying out the plans of care.

The focus of the surgical rounds is the doctor's plan of care. The Sisters bring any concerns with symptoms, the effects of the current plan, and possibilities for discharge to the doctors for their attention, investigation or referral. As "a seeker after information" (Int. 7-3: 22), the Sisters come with the knowledge of the patients on the ward and of the problems they are having and needing addressed.

Most of the rounds which I observed were characterized by joint planning between the Ward Sisters and their senior doctors. In most cases there is a shared view of the patients and the goals for care, but in some instances there are different understandings about the goal or the patients' potential. This most often happens when planning for discharge or when a patient does not respond to surgical treatment and is dying. It is usually the Sister who works to get them into synchrony again, working to get "everyone round to a SHARED view" (Int. 7-3: 27). Gaining a "shared view" is possible because of the Sisters' authority in the ward and the respect and collegiality which underlies the relationship between the senior doctors and the Ward Sisters.

As medical and nursing spheres of action are sometimes contiguous, the consultants and Ward Sisters have tacit understandings about boundaries of practice, based on mutual trust and respect. That respect allows the Ward Sister to push those boundaries in situations where they may hold different views on the needs of a patient. In one situation, Sr. Grant asks the resident to refer a patient to rehabilitation while the consultant is on holiday as she knows he is reluctant to have the patient leave the ward. Although she is "very hesitant to put the wheels into motion without discussing it with him" (Int. 7-3: 3), she does.

Sr. Grant: I didn't want to get into the situation of us having his wounds healed, then deciding we'd apply for rehab. And then having to wait a month, kicking his heels really until the bed was ready. (Int. 7-3: 3)

When the consultant returns from holiday, he makes a point of saying he has noticed the referral. Sr. Grant tells him "I took the liberty of arranging for [rehabilitation]" (W7D2-1: 12) and tells him her reasoning. Sr. Grant describes it thus, "I think it was an acknowledgement by us both that I was just pushing the boundary a little" (Int. 7-3: 4). Working together in everyday practice, the Ward Sisters and their medical staff find, test and reaffirm or change the boundaries of practice.

Following medical rounds, the Sisters call the nurses together to receive any new information from them and to give them an update on their patients. Although some of the work generated from the decisions made in rounds is the doctors', much falls onto the nurses.

Getting On With the Work: Keeping One Jump Ahead

To get on with the work of a shift, the Ward Sisters organize the flow of patients into and out of the ward, and help the nurses to organize their own workload. They keep the workflow going by monitoring the nursing practices and the care the patients receive, providing intervention, support and back-up where needed. To accomplish these things, the Ward Sisters literally have to keep "one jump ahead".

Sr. Calder: [...] I know I have always got to be a jump ahead. To maintain this workload, and get as much as possible out ... of the little we've got. (Int. 3-3: 17)

Organizing the Patients and the Nurses

On some of the wards, twelve or more people are discharged and as many again are admitted into the ward in a morning. To achieve a smooth patient turnover, the discharged patients have to be ready to go early. Sr. Calder has a reputation in the hospital of being extraordinarily skilled in managing the high turnover of her ward. She anticipates which patients are likely to be going home and includes that in her assignment to the nurses. For example:

Mr. Tennant :: sliced the top of the left index finger off :: If it's a usual finger, three doses of IV antibiotics and home :: No reason he can't get up. He has marked staining on the bandage so he'll have his bandage covered today. (W3D5: 3)

Before the doctors appear for rounds, Sr. Calder makes follow-up appointments for those patients whom she is sure to be discharged, but delays making those for whom she is less sure. She also has the discharge letters prepared for the resident, save for any unique discharge instructions and prescriptions. After rounds:

[...] Sr. Calder then sets about to discharge those patients whom [the registrar] has said could go home. [The resident] signs the letters [which also serve as the requisitions to Pharmacy for medications for home] and the housekeeper takes them down to Pharmacy. The drugs come up amazingly quickly. Sr. Calder gives those patient that don't require antibiotics pain killers from the medication trolley [a sheet of Distalgesic]. Sr. Calder tells me, "The minute they are discharged these young ones want to go. I need the tablets under control by that time." (W3D3: 6)

Knowing the patients, the doctors and their practices and how the hospital support departments work enables Sr. Calder to keep one jump ahead. She knows that once many of the young patients have received word from the doctors, they will not wait long for their discharge letter, follow-up appointment and medications (which are usually antibiotics and analgesics). She also knows that the Pharmacy Department workload in the middle of the morning is heavy so she ensures that the discharge prescriptions from her ward are among the first filled.

Through Sr. Calder's anticipation and quick action, by mid-morning the ward is ready for more new patients. Her pacing and timing is suited to the patients and situation of the ward. On other wards, where the pace of turnover is not as high, and where patients are not as apt to leave without the necessary medications, this quick pace is not as necessary. However, on all wards, the Sisters plan ahead for unexpected admissions. They follow a maxim of being prepared: "You must always have a bed in a prime situation in the ward, [...] ready [...] if you can" (Int. 2-3: 21). Being ready includes thinking ahead to the patients.

Sr. Aitkin: "So that they have the jugs and glasses on the locker and the chairs by the bed. [...] It looks as if you're expecting them. I don't like the patient to come in and think, "Now where am I going to go?" (Int. 1-3: 27-28)

Coming with an understanding of the patients and the workflow which is broader and deeper than inexperienced nurses', the Ward Sisters see different priorities and act accordingly.

Sr. Grant: [...] I start to [...] strip a bed and make up a bed for the expected admission. Whereas the student nurse. That patient hasn't arrived yet. That patient's nothing to worry about yet. It hasn't happened. She has other priorities. She's not [...] looking ahead in the same way that I am. So she finds it difficult to understand why Sister wants to stop and strip and make up this fresh bed when she's got things that she feels that she needs to do first. [...]

And it happens [...] the other way around. The student nurse who's not sure if she's heard her blood pressure correctly, who would like to have it checked by me, when I know this is a routine observation and the patient is WELL. And I'm not too concerned. It's a low priority for me to check that that blood pressure when I've got so many other pressing things to do. But that blood pressure's very important to that student nurse. (Int. 7-1: 12-13)

Where experienced staff nurses are not available, a good part of the Ward Sisters' time is spent helping the nurses to become organized and to set and reset priorities in a way that accomplishes the work, while providing a quality of care to the patient. Unable to count on taken-for-granted understandings, the Sisters often need to explicitly explain their priorities and actions. This can feel like "pushing" and "driving" the students (W9D3: 1).

Keeping the Workflow Going with the Patient at the Centre

With a clear overview of the work to be done and the potential for each patient, the Sisters are able to combine actions, anticipate problems and co-ordinate activities, helping the nurses to achieve the goals of care for individual patients while addressing the needs of all. The Sisters learn how to "use every minute you have, and not to waste one second of a nurse's time" (W9D3: 1). This does not come easily, particularly when there is an ever increasing workload and too few people to help.

The Sisters talk about "cutting corners" in such situations. "Cutting corners" is not easily defined, but central to its meaning is being flexible and paring down actions. The Ward Sisters are selective about which corners they cut and how they do it. They do not cut corners to save time in the short run, when the long term effect is compromised recovery for a patient. On a very short staffed day, Sr. Calder gets an elderly patient with a fractured humerus and infected chest up to sit in a chair before breakfast, so the arm would benefit from postural traction and he could breathe better (W3D2-2: 3). The Ward Sisters not only see the immediate task to be done, they have a broader plan for the patient and do what is necessary now to prevent complications later. They recognize what will and will not be time saving, taking this broader goal into their definition of what may be minimum nursing care. Sr. Calder describes how she sees the work organization differently than her staff nurses.

Sr. Calder: But they're not seeing it the same way as I see it. [...] Whereas they would see it - give him his breakfast in bed and then we'll be getting him up out of bed later. [to do his bath] [...] They would do breakfast first. They wouldn't see another job to do. (Int. 3-3: 27)

The Sisters understand their present actions as a part of a larger whole. They know where the patient is in the course of recovery, know where he has to get to and know what actions are required to get him there. It enables them to "see another job to do".

In times of staff shortage, sometimes only the highest priorities of care are accomplished.

Sr. Grant: You constantly have to sort through priorities and decide what you can do now what you can do later and what you won't be able to do. But there ARE things that you feel you should be doing. [...] It means that some important things like supervision of the the nurse learners just goes by the board. It's more important that the patient is washed and moved and comfortable than it is for the student to be supervised. You just hope for the best. (Int. 7-1: 11-12)

The Sisters say they can manage with cutting corners for short periods of time, but on a longer term basis, it interferes with student supervision and thus the standards of care. Consequently, morale suffers.

One of the several techniques used by the Ward Sisters to keep the workflow going for patient care is to maximize the effect of their experience. Sometimes it means that the nurses become something of an extension of the Sisters. When the man with postoperative bleeding needs diligent watching, Sr. Jarvis is specifically directive. She cannot count on the student's independent judgement and action.

Sr. Jarvis: And I felt it was up to me, not exactly to be looking after the patient on my own, but not relying on the nurse who WAS looking after the patient to pick up on the subtle changes that I was looking for. (Int. 10-2: 24)

The Sisters try to strike a balance between allowing the nurses independent action, while recognizing the needs of the patients and the nurses' limitations. As they give report, help a student to get organized at a patient's bedside, or do a procedure they often say, "The most important thing to remember is ..." (W8D2-1: 8). In this way, the Sisters help the students attend to the most important concerns, concerns they would be attending to if they could be there.

When she does not have sufficient nursing staff who can act independently, the Ward Sister can be in a difficult position. All are affected as the Ward Sister attends to "the one who needs me more than anybody else" (Int. 1-2: 19). On days such as these,

Sr. Baxter: I can't observe as a manager that the patients are getting the proper care and that everything's flowing, that they've had their x-rays and that their IV's are going and that they are pain free. And these things can all be dealt with. If I can't observe that and there are no nurses to do it, then it doesn't happen. And then what you end up with is a patient who is uncomfortable or in pain. (Int. 2-1: 24)

At those times, it is far more difficult to retain overview, monitoring and intervening when necessary.

The Ward Sisters attempt to have procedures accomplished in a timely way which support the patients' recovery. For instance, they are particular about when a person's urinary catheter is removed.

"Ask the night nurse to do a M.S.U. so we can take the catheter out first thing in the morning. We do it

that way rather than taking it out in the day so that if they piddle it is not at night which worries them. They will get it out of the way during the day."
(W1D1: 9)

They recognize that the incontinence which is likely to follow catheter removal is worrying to patients. A secondary consideration, but one which affects the care of others, is that during the day patients can more readily get to a toilet and there may not be the same requirement to change soiled beds.

Sometimes, the Sisters "plant seeds" with patients, so they are ready for procedures or baths when the staff are ready. The Sisters consider that allowing patients to prepare for procedures and negotiating with them about when activities are done is not only respectful, it engenders cooperation. It also helps to keep the work flowing. "You get more by going at their pace" (Int. 2-3: 6).

Ward Sisters co-ordinate procedures with the times doctors are available to the patients. In the midst of rounds, Sr. Jarvis asks a staff nurse to "do a residual on Mrs. Lester so it is done before the doctors go, and maybe she can go home" (W10D1: 5). Co-ordinating action in this way allows the patient to be evaluated more quickly and keeps her from having to wait in hospital for the doctor to return. It also has the potential to free a bed earlier than it might otherwise be available.

The Sisters also keep the work flowing by keeping one jump ahead of the doctors. Sr. Hanna picks up the results of the BCG (pregnancy) and ultrasound tests and begins to fast a woman who is most likely having a miscarriage and will need a Dilatation and Curettage. Her knowledge of the patient's history, the significance of the lab tests and likely medical practice means she can anticipate the required action. By beginning the preparations for theatre and by fasting the woman, she can get to theatre earlier. Potentially, this means less blood loss for the patient and through speedier treatment, possibly an earlier return home.

In summary, the Sisters keep the work flowing through their own actions and by actively supporting others. They organize and co-ordinate the work and intervene where and when necessary to move it along. They continually revise priorities for care, keeping a finely tuned tension between the needs of individual patients and the needs of all.

Solving Immediate Problems with a View to the Future

With a largely transient and inexperienced work-force, the Ward Sisters continually help junior medical and nursing staff solve immediate problems in such a way that they may solve similar problems on their own in the future. The Sisters do not take on others' problems: they set the scene for doctors and nurses to take responsibility with support.

The Sisters routinely help junior nurses to interpret signs, symptoms and patient conditions.

At report [Nurse Melrose] hears that Mr. Peters is to be "on half hourlies until he is awake, or if you are concerned, on half hourlies for 2-3 hours". About 3 hours later, Nurse Melrose asks Sr. Jarvis a question about continuing Mr. Peters on half hourly BP. Sr. Jarvis is about to answer, when she says, "What do you think?" Nurse Melrose says, "I could stop," and points to the BP going down into the 120/70 range. "It is what he had pre-op." Sr. Jarvis says, "Really?" (turning the sheet over and showing her the BP was higher) Sr. Jarvis points to where it is higher, "This could have been his pre-med and this because he was nervous". Sr. Jarvis turns the sheet back, pointing that the blood pressure trend is downward. She says, "This is reason for carrying on. Take it once more and see how it stabilizes." (W10D2: 11-12)

Guiding the student's observations and interpreting the patient's responses pre and postoperatively, Sr. Jarvis assists her to consider the larger pattern and context of the patient's physiological response. Such interchanges were frequently observed with all the Sisters.

The Sisters help the nurses learn to address problems directly.

[Sr. Hanna is sitting in the ward doing] her charting :: Nurse Cotter comes up and asks her, "What is this?", showing her a notation on the fluid balance sheet for [poorly written KCl] :: Sr. Hanna: "I don't know. I haven't a clue." Nurse Cotter turns and goes off to the doctors room. Bill, [the resident] comes back with her to Sr. Hanna and says, "It's KCl". Sr. Hanna: "I know, but I'm not here all the time". :: (W8D2-1: 19)

The Sisters support students to take responsibility in little things because they recognize the effect on the nurses' confidence and subsequent ability. With the staffing situation on most of the study wards, even newly qualified staff nurses have to take charge of shifts. "They don't have any choice" (W10D3: 12). The Sisters take various approaches to organizing the workload so that nurses gradually learn to take on more responsibility and are not overwhelmed and unable to function. On one ward that means giving a staff nurse or senior student responsibility for a team while the Sister retains overall responsibility for the ward. It "allows her to learn how to do a sensible patient assignment" (Int. 10-3: 14). As the staff nurse is given responsibility for planning all the care for the group of patients, she has to begin to think differently about the extent of that care. Instead of thinking:

Sr. Jarvis: "We haven't got to worry about: Mr. X. needs a bath today and then he's got a such and such dressing to be done. That's him [...] done." (Int. 10-3: 15)

The nurse has to realize that there is more to the patient's care:

Sr. Jarvis: He might have a wife that's not well. The doctors might be thinking that he's ready to go home later in the week. What are we going to do about getting him home. Does he need an ambulance and this sort of thing. They suddenly had to consider that it wasn't just Mr. X's personal hygiene and his wound healing that they had to deal with. It's all the other sides to him as well. (Int. 10-3: 15)

Taking responsibility for the care of a group of patients, the new staff nurse broadens her understanding of care and learns how to work with students.

The Sisters often give support and direction to junior medical staff. Decisions about admission and discharge are sometimes difficult for doctors to make. In the following situation Sr. Grant discusses what she was thinking when she suggested an alternative admission arrangement to a new registrar.

Sr. Grant: Several things. One [...] I knew that we were basically discussing bed state. But the niceties of it washed over me. Secondly because he's new to the unit, he is perhaps more willing to accept patients that would be more appropriately admitted elsewhere. So that rang a bell immediately. Here we have a diabetic in a medical outpatient clinic. Usually

these patients are admitted to medical wards, worked up and then brought over here if they require vascular surgery. So I thought [...] "This really shouldn't come our way at all." Thirdly that he wanted me to make a decision about when this patient would be admitted. Now that's not a nursing responsibility. And fourthly was the desire to help him out, because he was struggling. And it would have been easy to say, "Well I have a bed today. Yes that's fine. Go ahead."

M.M.: Mm hmm. But you didn't do that.

Sr. Grant: No, because the next time the same problem would crop up. And I might not necessarily have the bed. And he would not have discovered what the correct process was that way. (Int. 7-3: 9-10)

Sr. Grant shows that she understands the situation new registrars often find themselves in regarding admitting non straightforward patients. She gets under the surface of the request, acknowledging what he is asking, but recognizing that it would be an inappropriate admission. Had the patient been admitted to the ward, the registrar's judgement would have been questioned by the senior medical staff. Sr. Grant's knowledge of the usual admission practices allows her to help him to solve a medical organizational problem and see that the patient gets an appropriate medical referral. The registrar retains responsibility for the problem and learns to solve it.

Monitoring the Quality of Care and Being a Safety Net

Where many of the nurses are inexperienced, and frequently overworked junior doctors provide the on-the-spot medical coverage, the Ward Sisters play a vital role in monitoring and ensuring the quality of care, intervening when necessary. They provide a web of practices so that patients do not "fall through the cracks" and are a safety net for the junior medical and nursing staff.

The Sisters watch the doctors and nurses as they go about their work, listen to them as they work together and with patients, ask questions about their knowledge and expectations for their care, and notice the effect of their actions on the patients. They pick up on errors, spot omissions, intervene when junior staff members are "running into trouble" and seek assistance from more senior medical staff for decisions which are beyond the ability of the resident or registrar

in the ward. Such monitoring and intervention is done with finesse, and in a manner which usually encourages ongoing communication and cooperation.

Making an accurate assessment of a patient's condition or activity tolerance is often difficult for inexperienced nurses.

While Sr. Hanna is sitting at the desk in the ward writing her care plans, she is listening :: [...] to the [two first year] nurses getting Mrs Han [a 33 year old who went to theatre about four hours earlier for a laparoscopy] up to the commode. Sr. Hanna asks, "You weren't thinking of getting her up to the commode were you?" They say, "Yes." Sr. Hanna: "I think it is still early. Stay with her." (W8D3: 17)

Sr. Hanna acknowledges the students' assessment, gives her opinion and cautions them to stay with the patient to make their action safe. She questions their judgement and intervenes in a way which does not undermine their decision. In other situations, the Ward Sister may change the intervention. Sr. Grant responds to a nurse's request for pain medication for a patient; when she takes the medication to him, she identifies that the pain is angina, not simply limb pain. Through her different assessment and subsequent intervention, Sr. Grant ensures that appropriate, safe care is given. And to help the nurse learn from her error, she discusses it with her afterwards (W7D2-2: 16).

The Ward Sisters also provide support for junior doctors. This happens during the lead-up to Mr. Peet's surgery, which was discussed in the first section. After Sr. Ellis talked with Mr. Peet and his cousin in the afternoon, the senior resident, Dr. Campbell, takes Mr. Peet's cousin and her husband into his office to explain the upcoming surgery. After about twenty minutes, Sr. Ellis goes to her office to get something to file and then to the doctor's office where Dr. Campbell is talking to the couple.

She knocks [goes in] and puts the paper into the file. The conversation stops and Sr. Ellis turns to join in it. They talk about the cousin's daughter being called and coming in to see him this evening. The couple thank the doctor and go back to Mr. Peet.

Sr. Ellis asks Dr. Campbell how it went after they leave. He looks troubled and says :: "They're saying the right words. The things are going round and

round but you don't know if they're dropping into the right slots." Sr. Ellis nods. As we go out of the room, she says to me, "He's nice :: And he's only 24 :: it's hard for them." (W5D2-1: 15)

While she recognizes that the family need to hear about the plans for Mr. Peet from a doctor, Sr. Ellis is aware of Dr. Campbell's inexperience and his need for support.

Sr. Ellis: I went in just to look and go out again if I thought.. But I felt he'd got too deep. [...] And I could sense that going in. [...] So that's why we went in, to try and wind it up. Because I thought, "Well you can make things worse by going on and on into minute details and that." You know, there's only so much that people can take in.

And I could see just from his face and brow. [chuckle] The way the conversation was sort of dry and.. I knew he'd sort of done the nitty gritty part of the chat. So I'm really protecting him, more than anything else. (Int. 5-3: 24)

As well as tangible support for the junior doctor Sr. Ellis' action could also be considered supportive for the family as she prevents the situation from deteriorating.

The Sisters set up mechanisms for minimizing omissions, for ensuring that things "don't fall through the cracks". They recognize the difficulties the nurses may have attending to the myriad of details involved in caring for acute care surgical patients. One such mechanism is a wound check book in which all the patients whose wounds need checking are listed.

Sr. Inglis [...] says it might be old fashioned, but she found that nurses were missing it, and the junior students' assessments couldn't be trusted. "For example, see, Mr. Breen's was red, not 'fine' like [first year student] charted. I like the senior nurse or the nurse-in-charge to go round to see all the wounds ... Perhaps it should be picked up in the nursing process but Wounds are important, they can go wrong." (W9D1: 11)

Although such a list could be seen as an indicator of a routine task approach, here it serves to ensure a quality of care to individuals where many of the caregivers are inexperienced. The Sisters help junior nurses learn to build in regular

assessment of their patients by linking it with other aspects of their care. To help maintain a patient's fluid intake, Sr. Inglis advises the students to ask their patients to take a drink each time they use the commode (W9D2: 3). Sometimes Sisters keep patients on formal monitoring longer than needed, as a technique to ensure that the nurses regularly observe the patients. The ENT Sisters keep some newly post-op patients on half-hourly recordings slightly longer than needed so the nurses regularly go into the rooms to observe them. With the number of patients on the ward, the inexperience of many staff and their knowledge of human fallibility, the Ward Sisters ensure that the risks to patients are minimized.

Ensuring Continuity of Nursing Care

The Ward Sisters seek to achieve a consistent standard of care for each patient throughout all shifts. As discussed earlier, they accomplish this in part through staff allocation and patient assignment. However, ensuring continuity of care through the night shift presents the greatest challenge (Williams 1989). For eleven hours of every day the Ward Sister does not hold formal authority or responsibility for the care of the patients, although she remains accountable for their overall care. On many wards, an internal rotation of a staff nurse to the night shift promotes continuity of care, but it is only one nurse at a time and does not address other issues of formal authority. Continuity of care is also difficult to maintain through the constant turnover of students and junior medical staff. The Ward Sisters sometimes find themselves orientating new staff to the ward on a weekly basis. While ward manuals and guide-lines for such things as patient admissions help to provide a continuous thread, it is the Ward Sisters' expectations and everyday practices which enable continuity and maintenance of a particular standard of care

The handover reports at the change of shift provide glimpses of such practices. In preparation for a change of shift, the Ward Sister identifies who is coming on, the strengths they may have and/or the potential difficulties they may encounter. For example, when patients require diligent watching and the ward is busy, the Ward Sister may check to see if those coming on the night shift have the capacity to cope or if extra staff should be requested.

Sr. Jarvis: This gentleman wasn't well and I thought that he needed a close eye kept on him. [...] And it mattered to me who was going to be coming on because this was getting near to the time I was going to be handing over. And I had to think about whether they were going to cope. Or whether they were going to need somebody else. And in actual fact the next gentleman that came back on the same day, also had problems with bleeding. So we had quite a lot to think about.

So that was something else I considered, was the staffing and whether or not they were going to manage.

M.M.: And what did you conclude?

Sr. Jarvis: And in actual fact, I concluded that they would be all right. As the staff nurse who was coming on was quite capable. And she's always good to students, if you like, and the the mix was.

M.M.: The mix was good. Mm hmm.

Sr. Jarvis: Mm hmm. (Int. 10-2: 29-30)

It is not only the numbers which concern the Sisters, but the quality and mix of the staff; their capacity to deal successfully with the particular patients on the ward. This concern about the number and capacity of staff reflects the Ward Sisters' recognition of the fact that quality of nursing care is directly related to the nurses giving that care.

To help prepare the oncoming nurses at the handover report, the Sisters often cue them about what to expect. Reports to unknown or inexperienced staff are often very detailed. The Ward Sisters give specific directions about what to look for with particular patients and reasons for unusual or common but necessary procedures, for example, "He's having frequent oral care because he's fasting" (W9D3: 21). They give oncoming nurses specific directions.

Sr. Jarvis: I said to her that I wasn't happy with his wound at all. And I thought that it hadn't healed and it was gradually coming apart. And to make sure that she let the registrar see it when he came back on the ward round that evening. Explained that we'd taken out one of the deep tension sutures, and emphasized to her that we really had to make sure that they kept a close eye on it. And to re-change the dressing again on the evening shift. (Int. 10-2: 13)

The Ward Sisters organize themselves and their senior staff to give the most continuity and support to inexperienced nurses. They alter the workload where they can to ease the burden on inexperienced staff; and sometimes alert medical and senior nursing staff to the inexperience of the staff telling them to expect calls and to be supportive. In sum, they attempt to ensure a continuity and a quality of care to patients which transcends the shifts that they themselves are on.

Creating a Caring Ward

Creating and maintaining smoothly functioning, caring wards within the complex and ever changing organization of a teaching hospital is an ongoing task for the Ward Sisters. Primarily, they work to create an atmosphere on the ward which is healing for the patients and supportive for the nurses. This is accomplished in part through building their largely transient and junior workforce into a working team and by putting professional and educational supports into place which assist the nurses to develop their practice. Wards cannot work without necessary services, equipment and supplies. To get them in a system which does not always work smoothly, the Ward Sisters have developed ways of working with other hospital services and departments. This points to perhaps one of the more difficult aspects of the Ward Sisters' practice, reconciling overall organizational change and planning with the needs and concerns of the staff and patients on the ward. As leaders and managers of the ward, the Ward Sisters are pivotal in determining links to the wider organization.

The Ward Sisters play a central part in creating the ward atmosphere, the feeling of the ward.

Sr. Hanna: [...] I would like to think that every person that comes in the door of the ward is aware of that atmosphere and I would like to think that that atmosphere is there because of the way that I run the ward; the relationships that I form with the medical staff and the relationships I form with my permanent nursing staff. (Int. 8-1: 1)

In a ward, the atmosphere enables or constrains people's actions. When the ward atmosphere is a good one, both the patients and the nurses benefit (McGhee 1961, Orton 1981). On Sr. Aitkin's ward, a patient who had been on a number of wards told me, "You can tell a happy place... It is happy from the top. This is a happy ward" (W1D1: 5). Students also commented to me that the study wards were

"good" wards to be on. It seems that the little things which Sisters did or set up to happen were significant in making the atmosphere.

The comportment of the Ward Sisters influence the atmosphere. A patient described Sr. Aitkin: "She exudes confidence.... She has confidence in us" (W1D1:5). The Sisters share of themselves, and allow for openness and caring amongst others in the ward. Both work pattern and style comes into creating a ward atmosphere and influencing the other nursing staff.

Sr. Grant: [...] I think they tend to follow your pattern. Particularly if they're new to their role. They will absorb everything you do. And your style to a certain extent. (Int. 7-3: 19-20)

It is largely through their pattern and style of practices, that the Ward Sisters build a largely transient and junior work-force into a working team. This is particularly so on the study wards on Hospital B where the Sister is often the only qualified staff nurse on any particular shift. At Hospital A, a solid core of permanent staff and proportionately fewer students give rise to slightly different practices. However, it is through everyday practices that the Sisters encourage students and junior staff nurses to join with the more experienced staff to become a working team.

All of the Sisters make a point of warmly welcoming new students, staff and nurses who are assigned to the ward for a single shift. Sr. Aitkin talks about the patients and staff on the ward being all part of the "family" of the ward "while you are here". Even I was introduced as "part of the family for the week" (W1D1:2). Although the students are considered to be 'just passing through' the ward, the Sisters provide personal support to many of them when their work on the ward provokes personal difficulties. Often older and more experienced than other nurses who have higher status, the auxiliaries and/or enrolled nurses sometimes need particular support.

Sr. Hanna: And the whole atmosphere in the ward can be influenced by a strong personality that's not in a good mood if you want to put it. And so it's important that if you see this happening you try and do something about it quite quickly. And cause I always think it's infectious when one person starts getting grumpy it can easily be passed on to the next person. So you've got to make sure that it doesn't escalate. (Int. 8-1: 16)

Recognizing the early signs of a bad mood or being troubled, the Ward Sister intervenes to give the person some support. It may be to "say something to them that will make them feel better". Or it may be to take the grumbles "off her", to make sure she gets to coffee early, or to offer the opportunity to talk over a quiet cup of coffee. Through these and other forms of tangible supports, the Ward Sisters care for their staff and students and bring about a functioning team of nurses.

Professional and educational supports often take the form of reference material such as standard care plans, information sheets, books and articles. The Sisters make use of the talents of clinical teachers, senior staff nurses and nurses on induction or professional development courses. On some wards, the Sister arranges for the staff nurses to give regular tutorials to the students. They negotiate post-basic, induction and professional development course projects which are of benefit to the ward as well as to the nurse. On one ward, the Sister capitalized on a staff nurse's interest in patient education and encouraged her to write information sheets for the patients about common procedures and tests. The Sister smoothed the path with the surgeons, and the staff nurse was able to learn and grow while something important was gained for the patients.

Despite the busyness of the wards, the Sisters arrange for students to go to theatre to see surgical procedures. "It gives them an idea of what the patients go through and why they have pain" (W3D4:3). Students and staff nurses are also given opportunities to become involved with activities of patient self-help groups.

Even though these supports for learning and practice are sometimes unevenly implemented, they are a means through which the nurses' skills can be enhanced and professional contributions fostered.

To carry out the work of the ward, sufficient supplies and services are required. It is not always easy to get the needed services and supplies in a simple way. This includes services such as having a bed pan cleanser repaired or replaced or having specifically ordered patients' meals delivered.

Sr. Hanna: You know you cannot depend on just doing something and it will happen or requesting something to happen. It is never easy. It's always complicated. (Int. 8-1: 19)

To help the process of getting necessary supplies, the Ward Sisters get to know the people in other departments and how they can be best approached. Where the normal systems break down or an unusual request needs to be made, the Sisters use these relationships to obtain the services required for patients. The importance of having the necessary supplies on the ward is not underestimated by the Ward Sisters. They also get to know the usual flow of supplies which come from other departments. One Sister makes a point of hoarding linen several days before holiday weekends when linen supplies are unreliable and generally low. As the system of linen delivery changes, so does her hoarding. She maintains a flexible stance but protects the needs of her ward first.

The Ward Sisters work to keep the disruption and uncertainty of the organizational environment away from the ward. The study coincided with the introduction of Unit Management in the Health Board and corresponding organizational changes in the hospitals. Prior to and during the ten months of field work, the Sisters coped with organizational uncertainty, changes in reporting structure, changes in the provision of services by departments such as laundry, domestics (cleansing) and portering. One ward moved location and combined with another ward, another changed the type of patients and a third was the subject of plans to change it to a five-day ward. As well, there was a period of labour unrest, with several work stoppages by health care unions protesting insufficient health funding.

Sr. Hanna: All right it may go on all around about you, but I don't want that infiltrating into the ward. I like to try to keep the atmosphere different in the ward. (Int. 8-1: 19)

The atmosphere which is sought for the ward is one of caring and concern. The Sisters seek to protect the ward against the "stresses and strains" of the organization. Although they have a great deal of clinical authority inside their wards, most of the Sisters say they are often not consulted, nor involved in early stages of decision-making regarding nursing policy and organizational changes.

During such times, the Ward Sisters feel powerless and frustrated, as they are expected to make changes work even when they think the changes may be wrong-headed. At times they "Ignore half of them, I think" (Grp. Int. 1: 37). At other times they express their concerns to the nursing officer, or only accept limited responsibility. In accepting and making changes, they operate from the

perspective of what is best for the patient and the staff, and then what is necessary to survive in the organization. Being a semi-permeable membrane, by using their clinical authority in the ward, and cushioning the impact of organizational stresses, the Ward Sisters help the nurses to get on with their job, helping patients towards recovery.

THE NATURE OF PRACTICE

This chapter provides the context of the Sisters' practice from which we can examine the process of practising nursing and of becoming experienced. The argument thus far has been that experience is not static, but is fluid, multifaceted and inextricably linked to ongoing, moment-by-moment everyday practice. In this chapter I have argued that the Sisters' practice is patient-centred and complex, geared towards multi-layered goals.

The Sisters' practice and experience are influenced by the complex, ever-changing nature of their surgical wards. Centring their care firmly on the patient, the patient stay is the frame for the Sisters' practices with individuals, however these practices are always within the context of making the ward work for all of the patients. While their care of individual patients is geared to each patient's individual course of hospitalization and course of recovery, they approach the work of the ward on a day-by-day basis. Although the temporal frameworks for the care of individuals and the work of the ward differ, the Sisters always practise with an eye to the future and an understanding of the past.

The Sisters' practice does not seem to have separate clinical, management and teaching components as much of the literature would suggest (cf. Pembrey 1980, Orton 1981, Fretwell 1982). When their practices are closely examined separate components are not evident at all, not even components with "close interrelationships" among them (Runciman 1983). Rather, the Sisters' practice is complex and multifaceted. They often accomplish many goals simultaneously.

The Sisters are sensitive to the patients' needs from the beginning of their stay in hospital. The Sisters present themselves and create the possibility for a trusting relationship with the Sister and the other nurses. Such a relationship is critical for making the patients' stay in hospital, "a smooth passage". The Sisters do not stand apart from the patients. Rather, they engage the patient in a personal, yet

professional relationship. This is the point at which the Sisters begin to get to know the patients within the context of their hospitalization and surgery. Knowing the patients and their particular responses to surgery and hospitalization, enables the Sisters to tailor their practices to the individual. However, the Sisters give only a small amount of the direct care on a ward themselves.

Nursing care on a ward is a group endeavour. When patient problems are complex and require expert intervention, the Sisters will provide care themselves. For the most part however, they use their expertise to plan, monitor and evaluate the care that others give. Their efforts are geared toward assisting their largely inexperienced and junior work-force to provide quality care to individuals. The Sisters accomplish this through their practices in allocating the work, preparing the nurses to care for patients and supporting the nurses in giving that care. Sometimes directive, their practices are primarily facilitative. The Sisters actively work to create an atmosphere in the ward which is supportive for both the patients and the nurses (and doctors) caring for them. They guide the nurses in learning to recognize salient aspects of a situation and to take appropriate action. Characteristically, the Sisters work with junior nurses (and doctors) in such a way that they are supported while taking responsibility and learning to solve problems.

The Sisters continually strive to provide the best quality of care for patients that they are able to under the circumstances in which they find themselves. To this end, they keep the broad picture of the work of the ward and the course of recovery for the patient in mind. They sometimes have to "cut corners" but find ways to do it which minimize the negative effects on patients. The Sisters act as safety nets for patients and for junior and inexperienced staff: monitoring practice, preventing and picking up on the errors and omissions which inevitably occur. They develop a web of practices which help to prevent patients from "falling through the net" and missing out on necessary care.

The Sisters' practices are directed towards ensuring continuity for individual patients while ensuring care for all. They strive to keep the patients' families in synchrony with the changes in the patients' condition; they work to keep the doctors and nurses in synchrony about the plans for the patients' progress. Ensuring consistency in the care of patients from shift to shift with a continually

changing work-force is accomplished, sometimes with considerable difficulty, through clear communication at handover reports, as well as through clear expectations about the standard of care communicated through their everyday practices.

As the linchpin between the ward and the broader organization, the Sisters develop relationships with support departments and services which smooth the process of obtaining the supplies, equipment and services the ward and the patients require. They are not always successful in these endeavours, and are sometimes not as involved in organizational planning as they would like to be. Nevertheless the Sisters attempt to keep the stresses and strains of the organization from negatively influencing the caring atmosphere of the ward.

The discussion in this chapter reveals the importance of the context in determining the meanings of everyday practices. The Sisters' practices have meaning because they are in an ongoing situation. Thus the understanding we have of surgical nursing from the nursing textbooks (for example, Boore, Champion and Ferguson 1987), and of ward sister practice from the research literature (for example, Pembrey 1980) are but shadows of what actually goes on. The patient and the situation, the two essential elements of nursing practice, are overlooked in these accounts.

If we accept that nursing practice is contextual and relational then it seems important to examine more closely how the Sisters go about the process of practising surgical nursing.

CHAPTER 7

PRACTISING NURSING

The discussion so far has revealed experience and practice to be contextual and relational, forming and being formed by specific situations in particular times and places. When the Sisters' everyday practices are examined more closely, a process of practising is discerned. This process, of noticing, understanding and acting, is evident in the relational and contextual nature of the Sisters' practices. Although noticing, understanding and acting can be differentiated conceptually, in practice they are not so neatly segmented. Rather, they are inextricably intertwined in a non-linear, non-sequential process. The qualitative character of this process seems to contribute to the Sisters' practice being complex, multifaceted, goal-directed and centred on the patient. Arising from the discussion of this process are implications for the way in which we understand the nature of expertise in nursing practice.

NOTICING, UNDERSTANDING AND ACTING

Three distinct, yet inextricably intertwined processes characterize how the Sisters relate through their caring practices to their patients and to the ward. They are noticing, understanding and acting. Noticing is more than seeing, or hearing or assessing: it is a process of interpretation. Understanding is more than a surface knowing or recognition: it is a deep comprehension of meanings inherent in a situation. And acting goes beyond mere behaviour or deployment of skills: it is practising in a concrete situation.

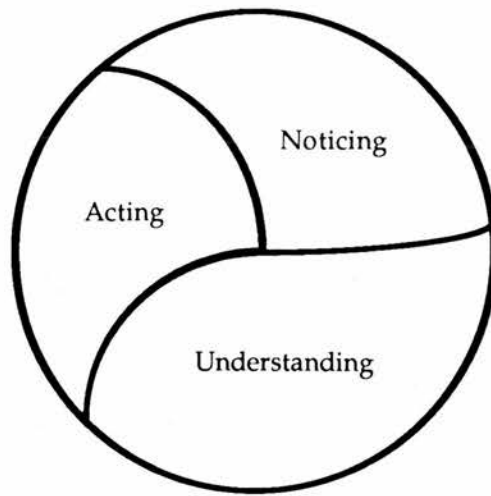


Figure 3. Noticing, Understanding, Acting

Through their involved stance in the situation, the Sisters notice salient features, understand their meaning and act, making the ward work; caring for the patient. Sr. Aitkin notices Betty's jeans, understands what they mean in terms of her readiness to begin to be "normal" again in social situations, and acts by "pushing", encouraging her to go to the pub's bar. As she helps him to prepare for the upcoming surgery, Sr. Ellis notices the character of Mr. Peet's protestations, understands - has a feeling that he is frightened and unsure, and acts, explaining "from the beginning". Sr. Baxter notices a student's "wee delay" in responding to her suggestion that she take out a patient's central line; she understands the delay to be a lack of knowledge and confidence and she acts, arranging for the student to observe the procedure again (Int. 2-3: 18). Noticing is made possible through the Sisters' experiences in previous, similar situations, which have made understanding possible.

Noticing and understanding are inextricably bound to the present context, as action occurs in an ongoing, concrete situation. Noticing and understanding are made possible by action. Sr. Aitkin is with Betty on the ward, watching how she prepares herself, noticing and understanding the meanings of her preparations. Sr. Ellis is present with Mr. Peet, understanding where he is in relation to preparing for a major loss. Sr. Jarvis continually experiences being with students on the ward, understanding how they learn to do procedures and noticing what happens to the student and the patient when they are inadequately prepared. How the Sisters go about caring for patients through making the ward work is an active, interpretative process. Even though they are intertwined in practice,

noticing, understanding and acting are separated here for the purposes of discussion.

Noticing

When Sisters notice aspects of a situation, they are paying attention to some things more than to others. They interpret the situation and identify what is salient, what stands out to them. The Sisters often notice more particularly and widely: what is salient for the Sisters is often overlooked by less experienced nurses. In noticing, the Sisters pick out what is meaningful and in doing so, interpret something *as* something. Noticing is grounded in their understanding of the situation and occurs in the flow of action. The Sisters' involvement in situations with patients and others in the ward sets up the opportunity to notice; they are attuned to what is going on about them.

Noticing the "Little Things"

In many instances, what the Sisters notice are "little things", which may be small, but are not unimportant. Sr. Aitkin notices when Mrs. Davies begins to take notice in something beyond herself.

Sr. Aitkin: [...] Freddy was a very nice budgie actually. [...] I'm quite sure [he] sensed when Mabel wasn't very well. That was the mystery. On the day she went to theatre he was very quiet. Normally he was chirp chirp chirp.

But Mrs. Davies who was opposite said, "I will talk to Freddy". She said, "Bring Freddy across to me". And she couldn't really see very well. [...] And she talked to Freddy the whole of the morning. And Freddy responded quite well to her. But she was concerned for Mabel. She was concerned that Freddy was worried about.. I mean I know that maybe it sounds trivial, but to me this has got importance. Mrs. Davies was caring about somebody else. (Int. 1-1: 18)

An action which may have been considered trivial and its importance gone unnoticed by others, is salient for Sr. Aitkin. She notices Mrs. Davies' action and understands its meaning in regards to her recovery. She knows that in illness a person's world centres on themselves; as they recover, they can look outward and care for others. This was a sign of a step forward. Sr. Aitkin's understanding of

recovery and her knowledge of Mrs. Davies, gives her an understanding of the situation and enables her to notice the significance of this action.

It is not only specific actions which the Sisters notice. They also notice how patients are: the expressions on their faces and in their postures. They notice what is said and what is not said, along with how it is said. Sr. Ellis notices how Mr. Peet responds during their conversations; she notices the pattern of the conversation, what is hidden by his protests and goes on to reveal and deal with his concerns. Sr. Dunn watches the patients' face closely when she dresses their wounds, noticing any sign of pain and adjusting her touch in response to what she senses. The Sisters are attuned to normal sounds and smells and notice small deviations from normal. They notice when someone's breathing pattern is changing; they notice small changes in the smell of wounds. When I noted her seemingly automatic smelling of the packing which she removed from wounds, Sr. Ellis expressed surprise,

"I smell everything, don't you? I can tell by the smell of a dressing, what antibiotic to use. :: But it's not scientific :: I can smell on people's breath, that they have cancer and will need a laryngectomy :: Yes, there's a cancer smell." (W5D2: 11)

As the Sisters develop expertise, the skill of their bodies give them access to a situation with less effort and increased sensitivity (Benner and Tanner 1987). They become more able to notice fine variations. Rather than being able to name specific components of what they notice, they notice wholes and discrepancies in those wholes - the smell of cancer on a person's breath, the feel of a circulation-impaired foot, the comportment of a patient in pain.

The Sisters have a finely tuned sense of the normal pattern of recovery of patients in relation to the workflow of the day and notice when things are not as expected. One morning, Sr. Inglis notices the empty bed of a man who is not supposed to be up walking on an infected foot. She finds him in the bathroom, reminds him he should not be up on his foot, and then has a quiet word with the orderly who got him up (W9D2-1: 11). The Sisters expect to see a certain pattern and timing of care and activity with each patient. When there is a variation, the Sisters notice; it signals action to be taken.

The Sisters' ability to notice more broadly yet particularly than less experienced nurses is evident when they notice salient features of the work of the ward. On her first day back from holidays, Sr. Calder takes a young man's intravenous cannula out, two days after it could have come out. Nurses giving him bed baths in those two days have not taken it out, nor sought permission to take it out.

Sr. Calder: But my professional instinct tells me he doesn't need that in. O.K. He needed it when he was having intravenous antibiotics. He doesn't need it in; take it out. (Int. 3-3: 28)

When Sr. Calder notices the intravenous cannula, she makes linkages: she remembers where he is in the course of treatment, that he is recovering and no longer needs intravenous antibiotics. The meaning of the intravenous cannula at this time for her is that it is an oversight in care. Her confidence in her judgement is such that it is now "professional instinct". Noticing prompts actions.

Throughout their workday, the Sisters notice the flow of work, gaps in the care of patients, how nurses are coping with their workload, how doctors are practising, how services are working and the feel of the ward atmosphere. They notice patterns and subtle changes or gaps in patterns, and respond to them. Noticing is holistic and situational.

Noticing All the Time

The Sisters talk about looking and seeing or picking things up. "You can stand at the nurses' station and look around and pick things up" (Int. 9-3: 51). They notice through the action of looking. "But you know, I can just sort of walk around and have a look and [...] I know, like at a glance. But that's something that you just, you're looking out of practise" (Int. 5-3: 20). Sr. Ellis looks "out of practise". She understands what she is seeing, even when it is "at a glance". Through their experience, the Sisters have come to be able to "read a situation" (Diekelmann 1990) and immediately focus on the problematic areas.

But even when they are not actively seeking, the Sisters are noticing. "You're always aware. You can always hear" (Int. 2-3: 24). As she is passing the treatment room on her medication rounds, Sr. Ellis hears a 12 year old boy crying as the doctor is cleaning his nose, a routine procedure. The other nurses, sitting near the room, do not notice. Sr. Ellis asks one to go to him and brings the boy's distress to

their attention, "It's awful at that age. He's young" (W5D2-2: 10). As they do not seem to be hearing, Sr. Ellis interprets the meaning of the boy's distress and his need for comfort. The Sisters are attuned to the normal sounds of patients and of the ward.

It is about 1120. Sr. Grant says to me that at about half eleven or twelve, everything goes quiet on the ward. "Everyone looks washed and their beds are made. If that doesn't happen and we don't hear that time, I know we're having a bad day." (W7D2: 13)

They notice when the normal sounds and sights of the ward change and interpret their meaning. Being attuned comes from experience and from being involved in the practice situation.

Promoting Noticing

The Sisters promote noticing in their interactions with students. With a patient who is bleeding postoperatively, Sr. Jarvis cues the student about what to keep "a very close eye" on (Int. 10-2: 21). Sr. Calder tells the students to compare similar responses of two patients to their different operations (W3D2: 4). Sr. Inglis asks directly, "He has a heparin pump. Do you know why?" (W9D1:17). She goes on to tell about this patient's particular problems with anticoagulant regulation. The Ward Sisters not only give factual information, they interpret the patients' conditions, cueing junior nurses about the salient features of the patient and his situation. They are helping the junior nurses learn how to notice, to pick up and to interpret.

Understanding

A Sister already has an understanding of any situation, a stance or prejudgement from which she interprets actions and meanings. She has, in Gadamer's words, "a horizon of understanding" (Gadamer 1975). This horizon has been formed in the Sisters' previous experiences and is how the resource of experience shows itself in current situations. Sr. Jarvis understands postoperative haematuria as normal or not depending upon its nature and the specific context. Sr. Baxter chooses to "go with" a patient or not from her understanding of the particular patient and their needs at that time.

Understanding includes sharing background meanings: sharing meanings of being a patient and a nurse; sharing cultural meanings of language, facial expressions, and human experience. Understanding is not just knowing facts about something. It includes knowing the meanings inherent in particular situations. Sr. Dunn, who routinely cares for patients with chronic chest wounds who have empyema tubes replaced weekly knows more than just how to insert an empyema tube skilfully. She has a broader and deeper knowledge - of the situation in which patients have empyema tubes inserted, of the meaning for the patient of a chronic wound, and of being an out-patient for a long period of time. Her understanding includes knowing what to look for in the patient's countenance and how to respond to what she sees there. It comes from knowing the patient in this instance in time, knowing the patient's history as well as having a shared history of previous encounters. Sr. Dunn's interpretation of the situation, interpretation of the person's response, interpretation of the physical ease or resistance of the tube as it is inserted are all grounded in her understanding of the situation she is in with the patient. Understanding comes from the past, is grounded in the present, but looks towards the future.

Understanding Enables Noticing

Understanding makes it possible for the Sister to have a non-reflective, direct grasp of the situation. It enables noticing. With experience, the Sisters come to understand what a "usual" or "normal" course of recovery is; what patients are like on successive postoperative days and notice when patients do not follow an expected or usual pattern. It alerts them to problems. A patient with "swinging" fever, whose breathing is "not quite clear" two days following nasal surgery is described by Sr. Fraser as someone who is "brewing an infection" or perhaps has a septal haematoma. She "doesn't look right" (Int. 6-3: 2-3). From their extensive experience of patients who do "look right", the Sisters have a complex understanding of what is normal, notices slight deviations and understands what might underly the altered pattern of recovery.

In many situations, the Sisters' understandings are confirmed, enhanced or augmented. However, such confirmation does not seem to have led to rigidity in their practice. The Sisters encounter new situations reflexively. They seem to consider their practice to be always open to question, and situations to be open to alternative understandings. As noticing comes from understanding in certain

ways, some meanings may be overlooked in situations. Sr. Hanna tells of a situation in which a woman who may have been in the ward following an illegal abortion was not picked up on.

Sr. Hanna: [Now] If they've got pelvic inflammatory disease then it's usually, due to the coil or the fact that they've had a termination of pregnancy and they've got retained products or something like that. [...]

I can remember as a student nurse working in Ward G and it was the time of illegal abortions. [...] And you were aware of things like that all the time. Nine out of ten ladies that presented themselves on a waiting night to your ward, it was because of an illegal abortion. [...] While I've been here as a Sister, it's something that is a way back, back at the back of your mind. [...] Unless there's other circumstances that bring it forward to your mind. [...] It's not something that immediately springs to mind when you have a lady in with pelvic inflammatory disease. While it was the first thing you thought of when someone came in with bleeding and temperature and everything. Twenty years ago you immediately thought, "Oh this is an illegal abortion". (Int. 8-2: 18-20)

Because there have only been one or two such cases in the last five years, Sr. Hanna's understanding of a woman presenting herself with those symptoms has changed. Although her knowledge about illegal abortion as a possibility has been in the back of her mind, since the legalization of abortion she has not been called upon to think along those lines. This situation has stimulated her to reconsider the understanding on which she bases her assessment of these patients - how she notices them; it reminds her to "think along certain lines" so she does not mis-assess such women in the future. In a significant sense, the Sisters are in dialogue, so to speak, with their practice. They are open to new ways of understanding, acting and noticing.

Understanding Informs Acting

Understanding always is in a situation and it shows itself in practice. It informs differing actions. On final rounds with the night nurses at 9:00 P.M., Sr. Ellis goes to talk with a five year old Greg's mother who is sitting on the next bed, watching television. The side rails are down on the lowered bed as Greg sleeps. Sr. Ellis does not pull them up. However, the night nurse comes into the room and puts

them up immediately, waking the child. She does not look at Greg or his mother; turns and goes out of the room. Sr. Ellis and the night nurse notice different things as they go into the room. Their understanding of the situation is differently informed (W5D4: 20). Sr. Ellis says of her understanding, "If there was a need Janet [the assigned nurse] would have had them up. She's been an enrolled nurse for two years. She's not a novice" (W5D5: 2). Sr. Ellis brings to her understanding of the immediate situation, her knowledge of the care the boy would have received from his assigned nurse. She does not notice anything "out of the ordinary" as she goes into the room. In her understanding of the situation, Sr. Ellis does not institute "protective" measures for the boy, she spends her time in the room asking his mother if she needs anything and how she is finding him. The night nurse, on the other hand, does not take into account these same understandings; she notices differently and her action stems from a different and perhaps less informed understanding.

Knowledge in Understanding

Both practical know-how and theoretical knowledge inform understanding. In much of the Sisters' practice, it is impossible to separately identify them. However, when the Sisters teach students, their theoretical knowledge becomes more apparent. Knowledge of pressure and its practical implications informs Sr. Grant's approach as she guides a student through the procedure of removing a central venous pressure catheter.

Sr. Grant goes to help Nurse Elias, a third year student take out Mr. Baker's CVP. Sr. Grant tells Nurse Elias, "If it is a positive CVP it means that the pressure in there (Pointing to his chest) is less than the air. If the CVP is negative, the pressure of the air is greater. What position should he be in if it is negative, to avoid having an air embolism?" Nurse Elias: "Sitting?" "No, that would decrease the pressure in the chest." Nurse Elias: "Head further down." "Yes." Sr. Grant then supervises as Nurse Elias takes it out. [...] As Nurse Elias takes it out, Sr. Grant says, "Give it traction, steady traction, pulling up. :: [...] Sr. Grant repeats at the end of the procedure that the most important thing to remember is to have Mr. Baker in a flat position. (W7D5: 16)

Sr. Grant does not go into the details of pressure in the chest, but reminds Nurse Elias of the relationship of posture to pressure and of the reading of the central line to air pressure. Although theoretical principles inform her instruction, she focuses on the practical knowledge of the procedure. Sr. Grant's understanding of central lines and their removal is neither solely theoretical nor practical. An admixture of theoretical knowledge and practical know-how shows in her practice.

Understanding also stems from the Sisters knowledge of themselves as human beings and relating to patients as fellow human beings. When Sr. Baxter suggests to a 20 year old appendectomy patient who is reluctant to move, that she wash her hair when she is up to the shower, the suggestion comes from her own understanding.

Sr. Baxter: [...] You know yourself if you're not feeling a hundred percent and you've been in bed for a few days, and you haven't felt up to the mark. What do you do? You like to have a bath and wash your hair and you feel so much better. You don't have to do anything else. Change your nightie. And you feel so much better. And that probably stems from ... you and feelings that you feel yourself when you're unwell. (Int. 2-2: 20)

Sr. Baxter calls on her own knowledge of the little things in normal life, things that make you feel better, to help a patient feel better in herself, to help her "over the hump". The Sisters do not stand outside the situation as onlooking, distanced professionals but are involved with the patient in the situation as a person, a nurse who can call on her understanding of being human.

Understanding in Context

Understanding is both formed in a context and shows itself in a context. This is particularly evident when the Sisters talk about knowing the patients. As much as the Sisters understand the patients as people, fellow human beings, they recognize they only know the patient as a patient here in hospital, that he or she may be "a different person" outside this immediate context.

Sr. Ellis: ... You know unfortunately we didn't know Mr. Peet ... before. We hadn't met him before his operation. Particularly because he'd had the trachy in-between times. But we felt in that day we got to know him fairly well. But

having said that in two weeks time you could see a completely different Mr. Peet, which might be the real one, you know. (Int. 5-3: 10)

The Sisters know patients as people who are in the midst of illness and hospitalization. As patients are on the ward for a limited time, they know them in a very specific temporal context. But within the limits and opportunities afforded by the context, the Sisters know the patients well. Occasionally, a patient can even become "an old friend" (Int. 8-1: 4) or "great buddies" (Int. 9-1: 11), but these closer relationships are still between patient and nurse; they remain contextual. Understanding the patients and the work of the ward is knowing in and of a context.

Sharing Understanding

Understanding is largely taken-for-granted and tacit (Polanyi [1958]1962). It comes forth in practice, often not coming into awareness. Understanding cannot be broken down into discrete bits or stopped in time. The flow of the Sisters' practice reveals understanding to be whole and fluid. Frequently, understanding and the noticing which arises from it is hidden, not only from the Sister, but also from the observer of her practice.

When we are at Mr. Ferry's bed, Sr. Calder asks him if he would like to go home today, that she thought he just might if the doctors feel he is ready. She asks him whether he could get transportation. He says no, that his wife could come in, but he would have to go by taxi. Sr. Calder says, "Yes, a taxi. Where do you live?" He says, "Just across the Common." Sr. Calder says, "Fine" and moves on. I ask him, "What floor does he live on?" (Sr. Calder makes a face at me) He says he has a second floor flat. (Sr. Calder doesn't say anything and just moves on - she isn't concerned.) *At the time, the thought went through my mind that Sr. Calder may not want to hold up the discharge, and she isn't concerned about his crutch walking, but I wondered why she doesn't have the physio check him out on the stairs (although I knew that physios had to be specially consulted today and it may be difficult).* (W3D2: 7)

[Later at coffee] I ask her about her decision about Mr. Ferry - why she did not pursue the crutches and his living on the second floor. She says that she

didn't even have it in the back of her mind until I asked the question, and then his managing on the stairs came to the front of her mind. Sr Calder replied: "I worked my way backwards", to when he came in. He came in on crutches and had been on them at home. So he would have had to have managed the stairs and would have had the physio teach him how to manage stairs. "Because that wasn't a concern at all", she says "I didn't pursue it." Had I not mentioned it, it would not have come to her mind at all. Not because she overlooked it, but because it didn't need to be there, particularly as she saw him walk [on crutches] last evening. She noted then how well he did ("You have this aced"). (W3D2: 10)

Sr. Calder and I come to this situation with different understanding. When talking to Mr. Ferry, I had forgotten about his solid success on crutches. Thinking that stairs should always be a consideration in such a discharge conversation, I assume it has been overlooked. Sr. Calder has already picked up on Mr. Ferry's ability on crutches, "working [her] way back" to when he came in. She understands Mr. Ferry to be a person who is capable of managing on crutches where he lives. As she interprets his needs for assistance in discharge, "that wasn't a concern at all". It is not to say Sr. Calder overlooks this aspect of Mr. Ferry's care, rather her understanding of him already incorporates this aspect. And she does not pick up anything in the conversation or in his actions in hospital to change it, to bring this concern to the "front of her mind". Her understanding is not readily apparent to me, and I misconstrue it.

Misconstrual of their practices by less experienced nurses and the frustration it provokes was described by several of the Sisters. It is like the tip of an iceberg. The contexts of understanding within which the Sisters operate are complex; they are easy to ignore or overlook when individual actions are all that are evident.

One consequence of having extensive understanding of patterns of activity and of taking knowledge for granted, is that such knowledge often cannot be easily expressed. However, just because it is difficult to put into words does not mean that understanding is absent.

Andrew [a 24 year old athletic looking man] is up on crutches with the physio. Sr. Calder watches him walk down the hall, out the door and towards the stairs. "He's away." I ask her how she knows. "Look

at him - just look at him - he's young - just look." I have to agree. A few minutes later, [...] the physio comes back with Andrew. She asks, "Was Andrew allowed to go home when he was safe to go?" Sr Calder: "Mnhmn" Physio: "He's safe." (W3D3: 7)

Describing a pattern, a whole, is not easy when our usual ways of describing are through properties or attributes. In saying "He's away", Sr. Calder is recognizing Andrew's ability on crutches. She sees his confidence in the whole of how he moves. She knows his recovery pattern so far and can project what it may continue to be. "He's young" reflects her understanding of his capacity and energy to become mobile and "safe to go". Sr. Calder does not describe the parts to me, she invites me to use my powers of recognition of patterns, my common sense. "I have to agree." By looking, really looking and noticing, grounded in my understanding of how people are and move, I join her in understanding.

When Sisters work alongside junior nurses, they frequently read situations together. It helps the junior nurses to develop their skills in noticing and also helps them towards new understandings. Importantly, it helps junior nurses to develop confidence in their abilities to understand situations and the context of human actions. Sisters sometimes ask patients' families to read the situation of recovery with them. Reading situations together allows the Sister and family to share understandings with the effect that both gain new insights and have the opportunity to notice differently. It creates a human sharing and a bond of common understanding.

Acting: Practising Nursing

Although acting comes third in this discussion, noticing and understanding have emerged out of ongoing action, the practice of surgical nursing. In Chapter 6, the Sisters' practice was detailed; this section extends that discussion by exploring several key constituents. The first is involvement, how the Sisters' care and concern enables their practice with their patients in everyday work situations. Second is how the Sisters maintain a flexible stance, changing their practice to suit the specific situation. Third is the confidence they have in their practice and the sureness and authority which stems from it. Although these constituents are identified for the purposes of discussion, they are inseparable from the Sisters' ongoing practice.

Practising From an Involved Stance

The Sisters can be said to be involved in and of the situation. Although involvement, in common usage, can mean "entangled" or "rolled up in", the Sisters are not involved in that way. Rather, they are involved in the sense of being "implicitly contained" in the situation. In her caring practices, the Sister is with the person, where the person is, both in space and time. They do not stand outside as onlookers, nor are they only there in body with their mind elsewhere. Being involved is understood to be a caring and "concernful" stance (Heidegger 1962, Benner and Wrubel 1989) from which the Sisters practise.

This stance neither drips with emotion, nor is it instrumental. It simply stems from the commitment of the Sister to care for people.

Sr. Dunn: I think you feel something inside you for these for people who are are ill and who need help, not in a 'I feel so sorry for you' attitude or anything like that. I think you just feel that you want to help these people. And if there's anything you can do that will make them better or .. make their life better you would like to be part of that. (Int. 4-2: 44-45)

This sentiment is aptly echoed by Altschul as she writes:

We nurses choose to commit ourselves to the sick, the helpless, the incompetent, not with any sentimentality or with any ulterior motive of bringing greater glory to ourselves, but simply because we have chosen an existence in which concern for the welfare of these people gives us a purpose in life. (Altschul 1979, 125)

This caring stance infuses the Sisters' everyday work. It is not only the patients and the ward which matter, the Sisters also care about the system within which they work.

Sr. Aitkin gives at report: "Morag:: from the renal unit [...] is to have Dextrose 10% and insulin and potassium, to keep her potassium levels as normal as possible at 20 ml/hour :: It is to go in at 0800 :: There's no point at putting it on at 0800, as the renal registrar is coming here to take blood for her potassium levels. It will give her the wrong reading :: We'll put it up after she comes."

The registrar comes up at 0835 and takes the blood. Sr. Aitkin puts up the solution about 0900 [...] At 0930, the registrar phones saying that the potassium levels are [?] and the infusion needs to be changed to Dextrose 5% with no potassium and insulin at 10 ml/hour. Sr. Aitkin grumbles about the cost to the health service and the inefficiency of it. (W1D2-2: 5)

Sr. Aitkin anticipates the doctor's actions and co-ordinates the intravenous infusion on the basis of that anticipation. When the doctor changes the order, Sr. Aitkin is not only concerned about wasted efforts, but also about the cost to the health service. It is not unusual to hear the Sisters say, turning off a light or conserving supplies, "We'll save some money for the NHS." The organization matters.

The Sisters' involvement shows itself in their practice, their understanding and their capacity to notice. Their concerned, involved stance enables them to notice meaningful aspects and possibilities inherent in the situation. Through their involvement they understand more deeply and broadly. Having said that, when an approach is not working well, or a problem is not amenable to the current solution, the Sisters "take a backward step and reassess the situation" and "find another way of dealing with it" (Int. 8-1: 5). In so doing, they gain a different perspective, notice differently, or access a different understanding. This stepping backward is not stepping aside. It is remaining *with* the situation, while finding another way of being in it.

Practising Flexibly

The Sisters practise in a flexible way, tailoring their care to the particular person and situation. This flexibility is possible because they have a very clear sense of their "ends-in-view" (Dewey 1925), helping patients towards recovery through both direct action and making the ward work. Their repertoire of experiences and skills have enabled them to notice and understand the alternative paths towards these ends-in-view which exist in any particular situation. Thus, the Sisters have complex goals for seemingly simple tasks. What appears to be delivering breakfasts or giving out medications encompasses a brief yet detailed assessment of the patients. The Sisters consistently respond to the inherent possibilities in the situation and tailor their practices to take advantage of them.

Far from being instrumental or mechanical, the Sisters' practices are purposive. The timing and pacing of Sr. Ellis' intervention to "protect" Dr. Campbell as he gives a family bad news turns a simple practice of monitoring and supporting into something that is unique to that particular situation and the people in it. Sr. Inglis' system of ensuring that wounds are checked is more than a simple routine. It helps to ensure a certain quality of care. The intentional nature of the Sisters' interventions take such practices from the realm of task or rote activities into the realm of thoughtful practice (Glass 1983). Rather than the Sisters' focus being on the task, it is on the end-in-view and on the goals for the situation in that particular point in time. It is by understanding the possibilities inherent in the situations, and by understanding that there are many avenues which will lead to their ends-in-view that the Sisters are able to practise flexibly.

The Sisters' knowledge and understanding allows them to "break the rules" in practice. They know when and how they can be flexible to suit the needs of the patients and the ward. Sr. Grant breaks her own rules about admitting patients when flexibility is called for (Int. 7-3: 10-11). She knows when she can be flexible yet still maintain her authority and clear role distinction. Sr. Aitkin tells the student to stop taking a dying woman's temperature. "We're not going to treat her with antibiotics :: If you take it you just worry about it." (W1D2-1: 17). She alters the routine for the patient's comfort; it also serves to focus the student's attention on the patient. When the Sisters break the rules it is for the patient. But when the rules are broken or theoretical knowledge changed in practice, the formal knowledge is not discarded. It is transformed into something which suits the situation. Sr. Dunn tells about how she changes the procedure of inserting an empyema tube from a sterile procedure to a clean one.

Sr. Dunn: [...] Sometimes I pick up the tube and I haven't got gloves on. Because I can't work, sticking that pin on. I try to be very careful and not touch anything. [...] You just have to use your own judgement. And you don't go and do things completely wrong. [...] I've probably adapted doing these dressings the way I find it easier for the patients. (Int. 4-3: 19-21)

Sr. Dunn maintains the principles of asepsis as much as she can, "you don't go and do things completely wrong", but centrally, she adapts it for the patients. As the patients need these tubes changed weekly over a long period of time, she adapts her practice to find a way in which she can keep the procedure as clean as

possible, yet as comfortable as possible for the patients. The Sisters shape their practice for the patients and the situation. "Your practice adapts continually" (Int. 7-1: 14). Just as the Sisters' understanding remains open to change, so does their practice.

Practising Confidently

The Sisters have confidence and a sureness in their practice. They take their confidence for granted; it is an essential constituent of their practice. A strong indicator of that confidence is that none of the Sisters take extensive notes about the patients, even though some deal with up to 50 patients in a day. Some of the Sisters take occasional notes about things to do for patients as they go on rounds. One writes reminders to herself in a notebook about administrative details, for example to telephone about getting blinds repaired. But importantly, even though some take notes, none refer to them except after the fact, or as a check to see that all the tasks have been done. They remember an extraordinary amount of information about patients, their conditions and their progress. How they developed this skill is discussed in the next chapter, but here Sr. Jarvis tells what it means to her to have this skill.

Sr. Jarvis: I feel it is nice to be able to be seen to know everybody and know what's happening without having to constantly refer to notes. I realize not everybody could work it like this, but I'm fortunate that I can. I don't like to see nurses, whatever grade they are, forever having to refer back to their bit of paper to remember who that patient is and and what's wrong with them. I feel being able to go around, as I do on ward rounds, without having to constantly refer back and write things down gives that air of confidence and knowledge in what's happening. And also makes the patient see that the nurse knows who they are. They don't need to look up the notebook to see which bed they're in so, "All right that must be her." "Oh that's what's wrong with her. All right, yes. I remember now." You know. So I think that's why I like being able to do it. (Int. 10-3: 20)

Their confidence is enabling. When the Sister is confident, other nurses and patients have confidence in them. "It's just they can trust someone who has a bit of confidence in themselves" (W5D2-1: 6). Confidence plays a large role in how the Sisters notice, understand and act. Confident in their ability to understand and manage certain situations, the Ward Sisters are able to attend to concerns

beyond the immediate situation. They notice more broadly. It is key to their being able to manage the tension between attending to one patient and attending to all in the ward. Having confidence in themselves, the Sisters can be more flexible. When they "can have confidence in others" (Int. 5-3: 20) they can delegate authority. And importantly, the "the confidence of experience" (Int. 5-3: 26) enables the Sisters to break the rules and tailor their practices to the situation. Confidence is crucial to the Sisters' effectiveness, authority and practice. "It comes with experience" (W5D2-1: 6).

The Sisters' confidence, however, presents something of a paradox. The Sisters continually keep their practice open to question, yet their confidence bespeaks certainty. Certainty, in a milieu which is notoriously uncertain and changing can become dogmatic and dysfunctional, precluding openness. (Katz 1988). However, this does not seem to be the case for the Sisters. The Sisters' confidence does not stem from the knowledge which labels and explains, rather it is interlinked with a knowing-in-practice which continually begs the question (Barker 1989).

A QUESTION OF PRACTISING EXPERTLY

Questions of expertise have repeatedly surfaced in this research. Are the Sisters expert surgical nurses? Does their practice exemplify expert practice? The study did not set out to address these questions, but they have arisen and have persisted. It may be helpful here to address them insofar as they can be addressed through the interviews and observations of practice.

An Expert or Practising Expertly?

When I first sought nurses to participate in the study, I asked for "experienced, excellent nurses". I was seeking nurses who had benefited from their experience. The notion of an "expert" nurse was not a comfortable nor familiar one within the nursing milieu in Scotland. However, the nursing administrators who were approached had no difficulty identifying nurses who were experienced and excellent, and who met the criteria (see Chapter 4). These criteria are consistent with those used by Benner to identify experienced nurses who were "recognized for their expertise" (Benner 1984, 14). Although Benner goes on to describe these experienced nurses as "expert clinicians" (Benner 1984, Benner and Wrubel 1989),

that step has not been taken in this study for two reasons. The first concerns the focus of the study and the second relates to the difficulty in ascertaining what constitutes expertise.

The study centres on the Sisters as they practise and experience, not on them as individuals outwith particular situations. Indeed, it has shown nursing practice and experience to be relational and contextual. It means that nurses cannot be deemed to be experts in isolation from the very specific and particular situations in which they practise. This study supports the use of "expert" as an adjective, describing practice, or more preferably as an adverb, describing practising, as opposed to using "expert" as a noun to name a person. Whilst the Dreyfus Model of Skill Acquisition (Dreyfus and Dreyfus 1986) and Benner's (1984) application of it to nursing emphasize the contextual nature of expertise, both Dreyfus and Dreyfus and Benner move from this position to name individuals who exhibit expertise, "experts". This move may not be problematic in areas of endeavour which are relatively uniform, such as chess or car driving, but in areas such as nursing which are complex, highly variable and continually changing, there are more difficulties. The very fact that nurses care for people make the situations in which they practice highly variable. Expertise in one situation with one person does not mean expertise in a similar situation with another. The Sisters may practise expertly, but labelling them "experts" and thus implying they are experts in all areas of endeavour, is inconsistent with the notion that their practice is contextual and relational.

What Constitutes Expertise?

Although this study did not set out to distinguish expertise, the examination of the Sisters' practices and their process of practising have provided a wealth of insights into practising expertly. When the study began, the Dreyfus Model, with its emphasis on experience and practical knowledge provided a useful touchstone for considering the practice of experienced nurses. The Sisters' practice has been found to be a process of noticing, understanding and acting. It is not an empty process, but one which is imbued with knowledge and skills in specific, concrete, particular situations. Thus, expertise as a descriptor of the quality of practice would need to concern both the process and the content of practice.

The Dreyfus Model is especially useful for directing our attention to the idea that expertise lies in practices and practical knowledge rather than in theoretical knowledge and traits or attributes of an individual. However, this study has illuminated some of the Dreyfus Model's limitations, particularly its emphasis on decision-making and its failure to address adequately the issue of the appropriateness of action for a situation.

Dreyfus and Dreyfus hold that a central characteristic of the expert is the use of intuition which shows itself in:

... involved skilled behavior based on an accumulation of concrete experiences and the unconscious recognition of new situations as similar to whole remembered ones. (Dreyfus and Dreyfus 1986, 35)

The six key aspects of the expert's intuitive judgement: pattern recognition, similarity recognition, commonsense understanding, skilled know-how, a sense of salience and deliberative rationality (Dreyfus and Dreyfus 1986, Benner and Tanner 1987), are present in many of the Sisters' practices. But there seems to be more to their practices than fluidly and intuitively approaching a task or making decisions.

Dreyfus and Dreyfus (1986) propose that a change from a distanced stance to an involved stance is a hallmark of moving from novice to expert. Following from this, it can be intimated that only skilled, expert practices can be deemed to be caring practices (Benner 1988, Benner and Wrubel 1989) as only proficient and expert performers are sufficiently engaged in the situation. However, being involved in a situation does not seem to be a simple or unitary action.

The Sisters' caring and involvement in patient situations does not seem to change with time. What changes is their ability to understand, notice and constructively practise in similar situations (Int. 4-2: 43). They become involved *differently*.

In their current practice, the Sisters often notice more widely yet focus more specifically and quickly on particular problem areas and the meaning for the patient. Less experienced nurses seem to be involved more narrowly and

inwardly, being more concerned with their own performance and the work to be done in the present than with the patient and their concerns.

Sr. Dunn: And as student nurse it was probably more important to me how I felt giving an injection, than it was how the patient felt. Again probably when I was a full time staff nurse it was probably more important to me how at the end of a shift how the ward work had gone. Had I coped, had I managed. Whereas now [...] I think I am probably able to think more about, has the patient managed or has the patient coped.
(Int. 4-1: 13)

This parallels Larsson's (1986) finding that when a teacher has taught for some time there is a change in his focus of attention "from the teacher's own acts and/or planning, towards the pupil's acts and/or thinking". This focus away from themselves may also explain, in part, why the Sisters found it easy for me to shadow them as they worked. Their focus was on the patient and the ward, not on their performance. Indeed, everyday physical and interpersonal activities are not mentioned in the interviews. They are taken for granted and the Sisters no longer "see" them.

Unlike the Sisters, student nurses do not take technical procedures for granted. They focus directly upon them. This is seen among the learners in Melia's study (1983, 1987) who consider nursing care involving technical skills to be "real nursing". This inability of nurses who are still concerned with mastering technical skills to see beyond those skills could partly account for why learners and newly qualified nurses take the doctors as their reference point, often not recognizing the knowledge of experienced nurses until they are more experienced themselves (Int. 3-2: 2). The knowing of the experienced Sisters is more complex; both "technical" and "basic" skills are interconnected in their practices. The focus of their attention in a situation is commensurate with this knowing.

In addition to the issue of intuition and involvement in the situation - the process of practice, the study provides insight into the importance of the content of practice in expertise. It would seem that to be included in expert practice, a specific intervention, replete with its implicit goals, its timing and pacing, would need to be *a* (not necessarily *the*) right action for the particular patient or situation and the nurse at a particular moment in time. Whereas a less experienced nurse may approach activities with patients serially, the Sisters "discover the possibilities inherent in the situation" (Benner and Wrubel 1989, 396) and create

complex goals which can be achieved simultaneously. This is the key to "being organized"; the Sisters are able to do it in circumstances which are ever-changing. The goals and the Sisters' practices which achieve them are qualitatively different than those of junior nurses. They are expressed in part, through a recognition and appreciation of differences (Diekelmann pers. com. 1990) in contrast to the junior nurses' seeking of consistency. This study did not look at the outcome of the Sisters' practices with a view to assessing their appropriateness. However it could be argued that such an assessment is implicit in the Sisters' practices as they continually monitor the effects of their actions and finely adjust them to the particular situation.

Thus, according to the Dreyfus Model, the Sisters could be said to be practising expertly in many situations. It would be misleading to suggest that they always practise expertly, or even with unqualified competence. Their practice simply was not addressed from an evaluative perspective. Having said that, it seems that this description of the practice of experienced nurses who had a reputation of being excellent clinical practitioners may offer some glimpses into practising expertly.

SUMMARY

This chapter has revealed that for the Sisters, practising surgical nursing expertly is closely bound up with how they notice, understand and act in practice and the knowing embedded in their practice. They practise from a caring, concerned stance, being fully present in the situation and with people. Patients, the ward and the organization matter to them. They notice broadly and particularly. Their interpretation of the situation can be counted on. The Sisters come to workday situations with solid backgrounds of understanding which inform and guide their interpretations in practice. Their understanding is situated and provisional. As the situation changes, so does their understanding. Dialogue characterizes their interactions; they are open with people and experiences in the ward. Flexibility, suiting their actions to the situation, is a hallmark of their practice. Like the expert nurses in Benner's (1984) study and in comparison to other nurses, in many situations the Sisters have a qualitatively different perception of the task environment as well as a qualitative difference in their actions and skills. They approach many decisions and carry through in their actions in an intuitive, fluid way. Lastly, their knowing in practice is temporal, located solidly in the present situation, but drawing from the past and acting towards the possibilities of the

future. The quality of their noticing, understanding and acting in their practice, as well as the timeliness, appropriateness and effectiveness of their practice, is how the Sisters may have become known as excellent, experienced nurses.

CHAPTER 8

BECOMING EXPERIENCED

A sense of the continuous interplay between experience and practice has clearly emerged from the Sisters' accounts and observations of their everyday practices. The Sisters have been shown to be 'experienced' sisters who are experiencing all the time. Taking the process of practising to be one of noticing, understanding and acting, I have offered a glimpse into how experience and practice may be interconnected. In this chapter, I wish to take this discussion a step further by exploring the process of experiencing which enables the Sisters to become 'experienced'.

In Chapter 5, I suggested that experiencing, the moment-by-moment process of being, of acting in a situation, involves learning. Learning was said to accompany experiencing and to be an outgrowth of experience. We do not have a very good vocabulary to talk about the ongoing nature of experiencing, perhaps because it is something we are rarely aware of at the time and because it is always in a particular context. We may talk about our practices and our knowing but it seems that we commonly express our sense of the movement of experience by the term, learning. The movement inherent in learning is reflected in the dictionary definition, which describes learning to be an action of gaining, acquiring or becoming. The Sisters use the word learning when they describe connections between past and present experiences and practices or when they talk about the meaning for them of particular experience. The ways in which they describe learning reflects its situational and contextual nature and supports Selman's (1988) contention that learning should be viewed as more than just being "inside an individual's head". Just as the Sisters' experiences are not private, but are public through language and practices (Taylor 1985, 264), so too is their learning which is revealed in their everyday language and practices.

It is not uncommon in the adult learning literature to find a separation of experiences into "learning experiences" and other experiences (cf. Jarvis 1987a, 1987b, Brookfield 1986). I have already pointed out the difficulties with this understanding of experience and have argued that a separation between learning experiences and other experiences could be considered spurious, because it seems that all of the Sisters' experience is potentially a resource in their ongoing

experiencing. It is proposed here, that for the Sisters, learning is not only a result of some particularly meaningful experiences: it accompanies all experiencing.

Conceptions of learning which focus on internal, mental processes, albeit processes which may be influenced by the social milieu, reflect a dualistic view of the person in which the body and mind are considered to be separate entities (Brookfield 1986, Jarvis 1987a). This could account for why these theorists and others hold that some experiences involve the mind in learning while others may not. However, the Sisters' accounts and practices stand in stark contrast: they reveal experience and learning to be as much in the Sisters' fingertips as in their minds. They confirm the unity of the body and mind (Merleau-Ponty 1962, Heidegger 1962). Through their bodies, the Sisters have access to an understanding of which they are not always aware, and which they may not be able to describe. This perhaps reflects the intentionality and the memory which resides in habitual, bodily ways of knowing (Benner and Wrubel 1989, Schilder 1989) and the view that all our experiences are "enfleshed" and that our body never "forgets" (Duden 1987). If indeed, our bodies never forget, then we can pick up in any situation in which we find ourselves, and therefore all situations are sources of learning.

Just as experience is an elusive and fluid phenomenon which does not lend itself to a uniform, simple description, so is learning. As it would be misleading to dissect and simplify this complex and multifaceted phenomenon, I hope simply to point the way towards an understanding of how learning shows up in experiencing.

LEARNING ALL THE TIME

In talking about experience and learning Sr. Inglis puts it simply yet profoundly, "It's happening all the time" (Int. 9-3: 35). This almost throw-away remark points towards the contextual and relational nature of learning. Just as noticing, understanding and acting depict the process of practising, so they could be taken to describe the process of experiencing. Taking learning to depict the movement of experiencing, it could be said that learning encompasses changes in noticing, understanding and acting. In addition, learning is made possible by noticing, understanding and acting.

In Chapter 5, the range and variability of the Sisters' experiences were described and the majority seen to be taken-for-granted or resonant experiences. Not surprisingly perhaps, their learning parallels this. Whilst there are certainly instances in which the Sisters describe having sudden insight, the majority of the Sisters' references to learning use physical metaphors such as "picking up" or "absorbing". These physical metaphors reveal learning which is gradual and sometimes imperceptible, though far from insignificant. They also reveal something of the fluid nature of learning, as new meanings are found in the juxtaposition of past experience and ongoing experiencing.

Learning as Sudden Insight

Gaining insight can be a sudden or a gradual process. Often sudden insights are part of watershed experiences. In the following experience, Sr. Aitkin has a flash of insight, she "suddenly learnt" about her own practice.

Sr. Aitkin: I think I can remember very well, maybe to the exact day, that I was put in my place by a staff nurse. Who I was very fond of and I think she was very fond of me. I [...] had a very busy thirty-six bedded female surgical ward and they were very busy this particular March. And I was on an early and I should have gone home, but I always liked to finish my own work before I go home. [...] And I was very concerned for this girl because I knew she was going to be busy. She was just about to start her drugs. There were patients coming back from theatre and there were the suppers to get out. Although we had a very good domestic who would have done [...] anything for you.

And I said to the staff nurse, "Would you like me to stay behind and help? Would you like me to do the suppers for you before I go?" And she turned to me and she said, "Sister would you PLEASE go home. I can manage." And I felt dreadful. I really did feel dreadful. And I thought, "Oh my." And it was like a slap in the face because we had a very good relationship [...]. And I thought, "Oh dear". [...]

I went [...] home. And [the girl I flatted out with] said, "God you're late again." [...] And I told her and I was actually quite upset about it. And she turned [laugh] and she said, "Well she did the right thing." And I thought, "OH!! nobody wants me." And then she said, "But Jenny you've got to stand back and let these kids develop. You're not helping THEM."

Although she said, "Who do you think you're helping? Is it making you feel good that you're staying behind." And yet she could see. She said, "I can see what you want. You want your patients all right. You want them to have their supper at six o'clock. But it's not fair on the staff nurse because she can't plan her own evening if you're going to be there all the time to do it." And they were both very right, VERY RIGHT. [...]

But I suddenly learnt well you can't just go on. (Int. 1-1: 30-32)

This sudden insight into her own practice comes for Sr. Aitkin in the aftermath of an unexpected rebuke from a respected staff nurse. Her immediate experience of being "put in my place" is reframed by her flatmate who helps Sr. Aitkin to understand the effects of not delegating fully. It is a milestone for her in gaining an ability to broaden her focus of concern from just the short term needs of the patients to the needs of the staff and the patients in the longer term. For her, it is key in her learning how to be a ward sister in a new way which is helpful both to her staff and herself. Sometimes however, insights are not quite as abrupt, they come after a period of imperceptible change and may not be as emotionally laden.

After nine months experience of being a ward sister, Sr. Inglis notices one day "... I was no longer apprehensive...." and she learns she is comfortable in the job, "... I realized that I was home." Such a realization transforms her confidence: "Now I feel no matter what was thrown at me, I may not know about it but I could handle it" (Int. 9-3: 10). And with the confidence, her experience of being a ward sister is transformed. She no longer is anxious, but becomes "expectant", and "always prepared for something to happen" (Int. 9-3: 11).

Prompted by noticing a difference in their own understanding or feelings about a situation or their work, the Sisters realize that they have learned about their way of being a ward sister. They locate their learning in a particular time and place, but it may have stemmed from a single experience, or from experiences over several months. These times of sudden insights are occasionally referred to as turning points. They are an identifiable point of change, when the Sisters' realization of another option or possible way of being changes their practice.

Learning as Having it Instilled Into Us

Learning in many situations is a more gradual and perhaps more passive process. Some of the Sisters spoke of nursing knowledge being "dinned into us" (Int. 3-3: 25), or "... just bred into you" (Int. 1-1: 27) by ward sisters and tutors, particularly during the early stages of their training. Living up to expectations, "having to do it" and wanting to do their best drove them. "We had to do it. And we did it" (Int. 3-3: 25).

The knowledge they learned this way: anatomy and physiology, the importance of working neatly or remembering patients' names, may not have been particularly meaningful at the time, but the Sisters have since recognized new meaning in it. Remembering patients' names was a skill developed early in training.

Sr. Jarvis: I can remember as a student on night duty.. One of the biggest worries on nights and it still exists for the students, is that the nursing officer is going to come into that ward at any time and ask you to do a ward round with them about the patients.

And you'd had report from whoever had been on and you'd written everybody's name down and their age and their diagnosis. And then you put it in your pocket and you'd got on with your routine of doing your temperatures and drug round and whatever else. And we used to then, if we had time after the patients had settled, sit and practise going round the ward in a set order.

Start at the 'left one' or whatever it was and reel off the patient's name and their age and their diagnosis, so that you learned it from memory. And it would throw you completely if they started the other side. [laugh] (Int. 10-3: 18-19)

Although the Sisters' skill of remembering patients begins early in training, it evolves and takes on new meaning over time, as Sr. Jarvis explained in Chapter 7. The way of remembering is also transformed.

Sr. Fraser: After a while, once I've got the patients in my head and I know who THEY are, I can monitor the changes that way. I can do it mentally, without writing it down. (Int. 6-3: 9)

A broader understanding of the patient and changed responsibilities have brought new relevance to remembering patients and changes in their care. The Sisters' way of remembering has changed from learning by rote and for the benefit of someone else, to learning "who THEY are", because it enables them to give better care. Thus it moves, from the instilling of the early years of training, to a more active way of learning because the Sisters understand the value and meaning of the skill differently with time.

Learning as Absorbing

While "having it instilled into us" describes a process in which the Sisters learn despite themselves, to suit the requirements of an authority figure, "learning as absorbing" describes a perhaps less obvious process of learning by example. Sr. Grant notes how staff nurses, "particularly if they're new to their role, will absorb everything you do, and your style to a certain extent" (Int. 7-3: 19). Bandura (1977) calls this absorption, "modelling". As Polanyi contends, this kind of uncritical imitation is necessary, particularly when much of the knowing which is to be learned cannot be specified in detail nor transmitted by prescription.

To learn by example is to submit to authority. You follow your master because you trust his manner of doing things even when you cannot analyse and account in detail for its effectiveness. By watching the master and emulating his efforts in the presence of his example, the apprentice unconsciously picks up the rules of the art, including those which are not explicitly known to the master himself. These hidden rules can be assimilated only by a person who surrenders himself to that extent uncritically to the imitation of another. (Polanyi [1958]1962, 53)

However, not everything about a person is absorbed. The Sisters also talk about ward sisters with less endearing qualities who greatly influenced them. Although an influential ward sister had a "very, very domineering manner", Sr. Hanna admired other aspects of how she worked, and took away from her "an ability to cope with anything at my work regardless of my home circumstances" (Int. 8-3: 27). The qualities absorbed from working with a ward sister would sometimes be cast in a new light, and perhaps deepened with further experience. Sr. Jarvis tells of a ward sister with whom she worked,

Sr. Jarvis: ... I absorbed her sort of ... efficiency, if you like. She was efficient to the nth degree. You just couldn't catch her out at all. (Int. 10-3: 27)

Later, working with other sisters, Sr. Jarvis learns that there are other qualities which help to make a ward work well.

Sr. Jarvis: [...] But up until I worked in Coronary Care Unit, I didn't realize that, yes you can be efficient, but it's also important that you enjoy your work and you make the most of the people that you're working with. (Int. 10-3: 27)

With the experience of working with several ward sisters, the Sisters recognize the possibility of different ways of practising nursing. Thus while the Sisters may trustingly and unreflectively absorb others' patterns of nursing early in their career, only later as they gain experience, are the patterns understood and changed or adopted freely.

Learning as Picking Up

Learning as picking up is linked to nursing practice as an active process of coping in the situation. The Sisters pick up ways of working with patients and the ward while they are in the situation. It is perhaps the most common way of learning in everyday practice. Learning may begin with noticing, but picking up includes a movement in understanding and acting as well. It is often impossible for the Sisters to identify when and how they "come to know", as picking up is so often gradual and seemingly incidental.

Picking up happens over time in practice. Sr. Dunn tells about how she learns how to respond appropriately to patients with chronic, draining chest wounds.

Sr. Dunn: I think you learn to say to them 'you're looking better'. [...] I probably found it, just by talking to them in the right way. It was probably better than saying, "Well, where does it hurt" or "Is it sore there? Well we better get an x-ray, we better get the doctor to see you." [...]

M.M.: So at one point in time you did say those kinds of things.

Sr. Dunn: Oh yes. I think so. I think just through dealing with them every week, and probably getting a bit fed up listening to

them every week. Think "Oh well I'll have to sort this out." And try [...] and NOT make it as if they've got a disease. It's just a part of their life now. [...]

I think it can be wearing on you when somebody comes in and there's always something wrong. I think it would be dead easy to say, "Oh what's it going to be this week". [...] And getting the doctor. [...] I think probably that the patient does that cause he's frightened as well. And if you can get them over that and try to get the message over to them that he's not going to come to any harm because of this. And 'or we'll deal with it' and it's not very nice but it's not really that great a problem. And then you find that they're not full of complaints every week. (Int. 4-3: 22-23)

Because she is in the situation, having to "listen to them every week", Sr. Dunn begins to hear the meaning of their complaints. She comes to understand how her approach is not helpful, notices the possibility of a different approach, and changes, finding a more appropriate way, "just by talking to them in the right way."

The Sisters also pick up what to do from making mistakes and being caught out. The mistakes may be their own, or they may be those of others. Sr. Baxter learns about the importance of clearly communicating with relatives from observing the difficulties encountered by a ward sister with whom she was working (Int. 2-1: 17-18). With mistakes, what is important to the Sisters is,

Sr. Grant: not making the same mistakes twice.
Knowing what your mistakes were and saying, "Next time I don't do it that way". [chuckle] (Int. 7-3: 39)

The Sisters monitor and change their practice because they care about their patients and their practice. They value doing their job well.

Picking up comes from being in the situation, "... it's learning by practising" (Int. 6-3: 33). Over time, Sr. Baxter learns how to unobtrusively monitor students and staff; Sr. Ellis learns to make fine discriminations in the smells of different wounds. Through experience, Sr. Jarvis learns just how fast a clot can form in a bladder. Her theoretical knowledge about clot formation takes on new relevance as she learns how fast it happens, and how the resistance in the catheter during the irrigation actually feels. The Sisters learn in their fingertips, in their sense of timing and pacing, from being in the situation.

Learning as picking up implies a finely tuned feedback mechanism. The Sisters are attuned: they notice what is going on; they pick up what went well, or what went wrong; they listen and hear, seeing the possibilities for alternative ways of understanding and acting. The situations and people in them matter; the Sisters willingly change their actions to become more effective practitioners.

THE ROLE OF NOTICING IN LEARNING

Noticing plays a key role in the movement of experiencing. It seems to provide for understanding and acting on the possibilities in the situation. In so doing it allows for learning. As discussed in the last chapter, the Sisters become ever more skilled at noticing fine distinctions in everyday situations.

The Sisters notice the little things throughout their workday: the subtle (and not so subtle) changes to familiar patterns which trigger new thoughts or actions. They recognize what is not there and what is there that shouldn't be. They see patterns at a glance, such as when Sr. Inglis glances around the ward and learns how the work is going. Over time, the Sisters continually deepen their web of understanding of patterns and sharpen their abilities to notice.

Attuned to the situations they find themselves in, the Sisters constantly notice the possibilities inherent in the situation. Sr. Baxter tells about how she has come to be able to notice when patients "haven't picked up" what the doctor has said.

Sr. Baxter: There's no set teaching involved. I think it's probably ... observation. And you can perceive you can just feel something in some people. And some people sometimes start to say something and stop.

And you can either pick up on that. And if you do, you can maybe probe deeper into what they're thinking. I think it's basically observation. It's something that's there by looking, and listening often. By what you don't say, by what you don't see as a nurse. Often you tend to see a bit more. (Int. 2-1: 23)

Through close observation and attention, stemming from their care and concern, the Sisters pick up small changes in their patient's demeanour. They are attuned to the silence as much as to the noise. They get feedback on their actions and alter their approach, constantly monitoring the patients' responses. Through this

process the Sisters learn more about the patients and their practice. Often the feedback cannot easily be put into words.

Sr. Drum: [...] You certainly get something between a nurse and her patients. Some kind of feeling. Well the nurse gets a feeling from a patient when she's done all she can for them. (Int. 4-3: 30)

The Sisters are constantly attuned to their patients, picking up the subtle as well as the not so subtle cues. Although they continually adjust their own actions for the patient, their concentration is on their work, not on their own performance. However, they notice the effects of their performance on the patients and on the work of the ward.

Noticing is not always at a glance. When the Sisters figuratively or literally take a step back to get another perspective on the problem, they reframe the problem, allowing different things to become salient, to stand out in the situation. In noticing differently, a new avenue for clinical judgement is opened. Although the framing of problems may be at the heart of clinical judgement (Schön 1983), noticing is central. It provides the material with which to formulate and frame the problem. The Sisters often actively help students to reframe problems in their work. In handover reports, they often prompt noticing, "Does that make you think?" (W3D3: 2); "What else would you look for?" (W3D4: 17). In their own practice and in guiding others, the Sisters open new possibilities through noticing.

Keeping Fresh: Continuing to Notice

There are times at which noticing is diminished. During times of illness, or when the Sister is newly back from holidays, she is sometimes not as involved in the situation as she usually is. Sr. Calder describes her feelings on her first day back at work following a relaxing holiday.

Sr. Calder: And that was alien to me. Sort of sitting back and being relaxed, instead of, you know, getting on with it. Because I know I have always got to be a jump ahead to maintain this workload, and get as much as possible out ... of the little we've got. [...] But yesterday I was a part of that canvas. I was sitting back at one stage. [...] I was aware of this. I thought, "I should be doing something, I should be doing something."

And when I got home at night I thought, "I could have done my pharmacy." It was all about going through what I could have been doing. But at the time, it never crossed my mind. (Int. 3-3: 17-18)

The Sisters avoid being only "part of the canvas". Keeping one step ahead and noticing small changes demands an active, involved stance. When they do not have that active stance, engaged in the rhythm of the work, they fail to notice.

Confidence enhances the Sisters' abilities to notice subtle changes, but the Sisters guard against the over-confidence or complacency which limits noticing. Although they take their knowledge for granted, the Sisters actively work to avoid taking patients for granted. They have different ways of keeping themselves fresh in order to notice.

Sr. Ellis: You know it surprises me. You see people coming in and they're sort of unwell for a day and the next day they're up and around. When you see the children. I mean when they come back from theatre they look TERRIBLE, they're so pale and and it always amazes me when you see them in a few hours. I still always.. I have a fear of ... anaesthetics.

And when patients come back from theatre they always look terrible. It was since the first patient I ever saw when I started my training. I thought he was going to die. [...] And afterward I couldn't believe it when he got well. And I still never am completely comfortable until a few hours after they recover from their anaesthetic. I don't think that's a bad thing. I think sometimes you can become too confident.

[...] You cannot become too confident. And you try and make sure the nurses know that there are always complications. You should be aware and to watch for that. (Int. 5-1: 15-16)

Sr. Ellis actively recalls her first patient who surprised her with his ability to recover from the anaesthetic. She cherishes this memory and uses it, to keep her from becoming complacent, to keep herself noticing. Like Sr. Ellis, the other Sisters take something which was important, surprising or shocking at the time to serve as a touchstone in their current practice. The meaning in the original situation is retained along with a continuing, deeper meaning which they use to help them notice.

The repetition which dulls or constrains noticing is particularly a problem on wards with a high turnover of patients with similar conditions. It is also a problem for very experienced Sisters whose experience allows them to view a vast number of conditions as routine. One morning, Sr. Calder notices a young person on his way out of the ward.

Sr. Calder: [He] was absolutely petrified going to theatre and I hadn't picked that up preoperatively. And he was only going for something minor. But completely uptight. And I just felt that I hadn't been with that one long enough and taken time. [...] I tried to reassure him on his way out the door. But you know he was on his way by that time, which I felt was too late. And I hadn't picked it up earlier. [...] I felt I had fallen down because I hadn't picked it up before then.
(Int. 3-2: 15-19)

Whilst the turnover of patients and workflow is constant, Sr. Calder expects herself to pick up on the individual patients' concerns. When she misses some, she is reminded that the repetition she is experiencing is affecting her ability to notice.

Situations like these serve to jog the Sisters' understanding of their own practice. Sr. Calder consciously examines what is happening to her when she fails to notice; Sr. Hanna rethinks the line of reasoning she uses in examining women who come in with missed abortions; Sr. Ellis consciously remembers her fright about not knowing if the patient would wake up. Others talk about how the students keep them fresh (Grp. Int. 1: 21). But primarily, it is the patient and the Sisters' concern for them which serve as their main prompt.

Thinking about the patient, noticing all the time and being comfortable in their own practice, allows the Sisters to monitor the effects of their practices and to continue to modify them. Unlike some of their junior nurses who are so flustered in a situation that they cannot absorb "anything from anyone" (Int. 10-2: 4), the Sisters' stance in practice allows them to continually pick up from others. They share a deep commitment to always keep their practice open to question and to take neither their practices, nor the patients for granted.

REFLECTING: HAVING A DIALOGUE WITH EXPERIENCE

In the movement of experience, understanding deepens and changes, in part, through reflecting. The Sisters practise thoughtfully. Whilst their perceptions and actions are fluid, and frequently intuitive, they do not "bash on" when they are stuck (Grp. Int. 1: 28). Rather they think in the midst of action.

Schön's (1983) delineation of reflecting-in-action and reflecting-on-action is useful here. Reflecting-in-action, the Sisters get a feel for the situation, pick up on concerns or changes and alter their practice to suit. Reflection is not necessarily visual, nor in words. In the care of wounds, for example, it may be by feel or smell. The Sisters also reflect in the midst of action more deliberately and consciously as they "take a step back" to get a new perspective on a problem, as they link and compare aspects of a current situation with previous experiences, or when they sit down to think through a discharge plan. This could be considered deliberative rather than calculative rationality. According to Dreyfus and Dreyfus (1986), deliberative rationality is characterized by intuitively contemplating differences and experiencing a situation in light of previous situations. Approaches are planned from a consideration of the relevance and adequacy of past experiences which seem to underly a current intuition. This is in contrast to calculative rationality which is drawing inferences from isolated, objective, abstract facts which describes the problematic situation. As they reflect-in-action, the Sisters stay within the situation, directing their attention to the patient and the ward.

In the midst of their workdays, there are few occasions for the Sisters to reflect on their practice, on their understandings of their own noticing and acting in practice. That is not to say it does not occur, but their attention is far more frequently focused on the happenings in practice. The Sisters more commonly learn in the midst of experiencing practice than through separately reflecting on their practice.

Linking Experiences

Throughout their everyday practice, the Sisters make links and connections. Reflection often starts in the form of a question which stems from noticing such a link. Sr. Baxter tells of when she was a new ward sister, she began to notice things

were not being "done properly" and linked it to her senior staff nurse who "appeared so confident".

Sr. Baxter: [B]ecause I was a wee bit insecure, I had let her mislead me into a false sense of security. Because I thought she knew exactly what she was doing. And I found out that she didn't. And maybe from there I started to think now, "How can I organize my workload and organize the nurses and check on them without actually breathing down their necks all the time?" (Int. 2-3: 14)

Noticing that the staff nurse was not as competent as she appeared to be, opened the possibility for Sr. Baxter to find a different way to monitor the nurses' work. Her questions are framed in action and pose the way for considering action differently. She begins to develop new approaches, such as finding discreet ways to accompany a nurse while she dresses a wound. In practices such as these, the Sisters make links, calling upon past experiences to reframe present understandings, in order to act differently in the future.

The Sisters are constantly comparing (cf. Clark 1989). They compare the smell of a dressing to normal wound smells, a patient's recovery to a normal recovery, the settling in process of a student to how students usually settle in to a ward. They use comparison to help students and patients learn. Sr. Calder calls on a patient to recognize what his normal limb can do and compare his progress in moving his impaired limb (W3D4: 5). She calls on students to notice the similar responses of patients to surgery in different limbs. The Sisters learn themselves through comparing.

The Sisters compare similarities and differences, both gross and subtle. They compare situation to situation, and sometimes only aspects of a situation. In the second interview, Sr. Baxter reviews what has been going on in the ward over the past several months. She tells about several patients who have had colostomies, yet are recovering differently. As she tells about each situation, links emerge: links of age, diagnosis, type of surgery, results of surgery, complications and how each is progressing, how their family relationships affect their recovery, how they feel about the colostomy, and what is most important for each in their recovery. In comparing, Sr. Baxter wonders at the differences among women and their families in coping with grave illness. Her comparisons disclose the meanings in the situations for her.

Sr. Baxter: The fact I suppose that you've got to be humble because Christmas was coming and Christmas is so commercialized these days and the only thing that she wanted for Christmas was the gift of life. And come Christmas Day she felt that that was what she had got. The best Christmas present she had got was the chance of having another year with her husband or however long it was and for that she was grateful. Material things weren't of any importance. (Int. 2-2: 25)

Sometimes the meanings revealed are personal meanings for the Sisters as well. Personal links are also made between patient situations and their own family experiences as they consider their approach to a situation.

Sr. Calder: You know I think, "Would I like my Mum to have that? Would I like my Father to be like that?" When you see some of them, what's happening to them. Would I have liked that to happen to him? (Int. 3-3: 44-45)

Links and comparisons made by the Sisters are not unidimensional, nor simple. They are complex and temporal in nature. They open the possibility for noticing both continuity and discontinuity. Comparing and linking allows meaning to come forth.

Remembering: It Comes Running Back to Me.

Linking not only occurs among aspects of current situations. As they move through their workday, the Sisters call upon their memory of a large number of details, integrating them into their understanding of the patient and his recovery, and current situations in the ward. They seem to remember where each person is in the course of their recovery, and link it to what they notice at the time. When Sr. Calder helps Mr. Ferry plan to go home, she does not specifically ask about walking with crutches on stairs, as she remembers when Mr. Ferry came into hospital (even though the memory is not in the front of her mind). The Sisters make links between what they notice throughout their workday with patients and what they already know about the patients.

Sr. Fraser finishes the drug round and is in the medication room when a student comes up and tells her that Mrs. Garson vomited her supper :: Sr. Fraser says, "That's odd :: That happened when she came

back [from the liver scan the previous day]." (W6D5:
12)

The Sisters experience patients in an historical context. When they sense something different or unexpected about a person, the Sisters link the current situation to previous experiences with them. They put the present instance in the context of a norm or pattern and note possible meanings in the variance. Constantly noticing, the Sisters pick up bits and pieces that are brought to bear hours and days later in assessment of a comment or situation. They are continually learning about the patients and the ward.

Just as the Sisters remember details about patients throughout a day, so they remember some patients after they go home. There are only a few patients who "stick in your mind" (Int. 4-2: 44), particularly on wards with a high turnover of patients. "Routine" patients who progress normally are not memorable for the Sisters. Patients who have a difficult-to-solve nursing problem or who are particularly impressive people are remembered. So are those whom the Sister gets to know because they are in the ward repeatedly or for a much longer than usual period of time. The Sisters also remember patients who help them to learn something about themselves. This may be why so many patients in the Sisters' early months of training are remembered. With increased competence and comfort in situations, patients do not stick in the Sisters' minds so vividly. Also with increased experience, the range of normal variations broaden, making fewer patients particularly memorable (Int. 3-2: 11-13). For the most part, patients are remembered when a particular context is evoked: only a few are remembered outright.

Sometimes memories are especially vivid. Sr. Dunn tells of her first death.

Sr. Dunn: I think I got a shock. I can still picture that man. [...] He was a big man. I can still see him sat up in bed. I think you never forget that. Well I mean that was twenty odd years ago. And that's just something that sort of stays with you cause you've also got that wee picture there you can go back to.
(Int. 4-3: 5)

Some situations like this are remembered outright and are not linked to present nursing practice. Other times, the Sister consciously links previous experiences with her current approaches. In the midst of caring for a patient, the Sister may

compare her experience in this situation to her experience with previous patients. Most times, the links the Sisters make seem neither conscious nor specific.

Sr. Jarvis: I don't know that I think of specific patients um... I don't think I thought of anyone specific when that happened to him. I didn't. I just remember having been through this before. (Int.10-2: 27)

Such memories are often less visual but they disclose the possibilities in situations. The memory of "being through this before" seems to evoke confidence and knowing.

The Sisters use such links and memories to assist learners. Sr. Inglis helps a student faced with a complex patient to draw on her experiences of competently dealing with each aspect of the technology surrounding the patient. By breaking it down into parts, and remembering her past successful experiences, the student sees the possibility of handling a more complex patient (W9D2-1: 3-4). The Sisters help the learners to recognize that they have previous experiences which can be linked to current situations. They help the students to use their capacity to remember. Constantly drawing upon memories of previous situations and making linkages, the Sisters create a deep web of situational understanding.

Telling About the Experience of Practice

Part of reflecting in practice is telling about the experience of practising. In everyday practice, in the handover reports, throughout the work day and outwith the work situation, the Sisters tell about their experiences with patients and the work of the ward. Telling about experiences is usually in conversation with themselves or with others; some is in writing. It seems that telling about experience takes at least four forms. One is recapping, or reviewing for the purpose of solving problems or confirming decisions. Closely linked is making sense through telling. Disparate elements are joined when telling about a patient or situation and new sense is made. Telling allows naming of phenomena, and in naming, the phenomena take on new importance or relevance. Lastly, telling is a form in which knowing about practice is passed on to others.

Recapping and Confirming

Telling is often a form of solving problems, reviewing practices and making plans. The Sisters talk to themselves about their patients and their practices, sometimes silently, sometimes out loud.

Sr. Aitkin: [W]hen I go to bed I do a little ward round in my brain. [...] I just go around every patient and [...] I think have I done anything for those people today. "Ah tadatadatada ah Mavis I gave a placebo to. Was that the right thing to do? Well yes because she's quite happy, and ... no problems. She'll sleep well tonight because she had her MST. Glynis, well Glynis is a bit grumpy tonight maybe she'll..." But I'll switch off eventually. [...]

M.M.: Do you ever come in with new things on your....

Sr. Aitkin: Oh yes. Often when I'm walking up to work in the morning I think well I've changed my mind about that. We'll do such and such for Mrs. so and so today. Yesterday while I was giving the report it came to my mind, because the weather was nice, to take them out for a walk. (Int. 1-1: 35)

Hearing themselves may bring out new meanings in the situation. Sr. Calder is talking to me as she makes follow-up appointments for discharged patients. She is thinking aloud.

"He has an ulna and radius. He's a Thursday. Yes, He's definitely a Thursday. I've told you, so I've convinced myself."

We then talked about it. She said, "Talking out loud - It [what she has said] sounds right. I was wondering where does one differentiate between a hand and an arm." [Thursday is the general fracture clinic, Wednesday is the hand clinic.] (W3D2: 7-8)

Articulating thoughts allows for a new framing or focusing of a situation, problem or solution. It reveals new meanings. In all instances, telling about experiences places those experiences in language. And through language, the meanings in the experiences are disclosed (Taylor 1985). As the Sisters tell about their practices, they preserve and extend those practices by focusing them (Dreyfus 1987, 275).

Making Sense

Telling about experience may prompt new connections. In telling me about what they were doing, the Sisters often said, as Sr. Inglis does, "I don't think I've consciously thought of that before" (Int. 9-3: 28). Bringing their hidden practices into the conversation enables new meaning to come forward. As Sr. Grant tells about similarities between two patients, she discusses their families.

Sr. Grant: I think we got to know them very well. We understood their strengths and their weaknesses. And liked them on a personal level; found them admirable. Not always easy but the relationships were very satisfying.

I've never thought about that link, you know. I think it's very true, the link's stronger between the relatives than it is between the two patients. (Int. 7-2: 13)

The link had been there, but hadn't popped into her mind. Making new links creates a new sense of connectedness; new meanings are found in experiences. Telling about experiences may not overtly change the Sisters' own practice, but it may change their understanding and how they notice. Telling can be described as a process of noticing which opens the potential for learning.

Naming Practice and Experience

Naming practices can bring new awareness. Sr. Fraser tells about learning the meaning of "gently mobilizing" in her first ward as a student working with a staff nurse and a particular patient.

Sr. Fraser: In the morning she was raised on one pillow for her breakfast with her towel by her side. And she was bed bathed, and it was a full bed bath. And she got up to go to the toilet and we made her bed and she sat in the chair by the bed. And then she was actually put back to bed afterwards. And then she got up again in the afternoon to sit and go through.. (Int. 6-3: 13)

Naming the timing and pacing she experienced with the patient and staff nurse as "the way you 'gently mobilized'" allows Sr. Fraser to understand an experience as something. Naming an experience or practice can also provide the Sister with a

means for pointing out hitherto tacit aspects of their practice to students. Naming is different than affixing a label.

"An experience that is named in one way at one time can well be understood differently later and the interpretation reconstructed as the person grows and develops." (Griffin 1988, 9)

Naming enables recognition and interpretation. It reveals meaning. Naming a process is also empowering (Griffin 1987). It puts the experience into a public space, articulating it and bringing it into focus.

Sharing Experience

Telling about experiences enables the Sisters to share their understanding and their practice.

M.M.: What's the most useful way of talking about your experience? [...]

Sr. Ellis: Well mainly with sort of colleagues on the ward. And even when you go down to tea and you speak to.. But mainly people within the unit, really, [and] the post basic nurses [...] For example Mrs. Sampson's [facial rebuilding] operation. There are not a lot of these operations done. And so we're able to say, "Well there's not a lot done but what we've experienced is this this and this. And we had this lady and how we feel.. That they all look the same, these people, you know, men or women; these people that have an ear removed and a facial palsy. And they all seem to look the same, the same face, with no facial expression." [...] Before they're all individuals and afterwards they all seem to look.. And that's the something to be prepared for or to be aware of. (Int. 5-3: 32)

In handover reports the Sisters place observations such as amounts of drainage, vital signs, and distances walked in the context of the person and their course of recovery: "We colour it in" (W8D4: 8). The Sisters often tell how they were able to accomplish a task with a patient or achieve something in the system. For example, Sr Fraser tells an oncoming nurse about the process which she used to get hold of the resident when the telephone system was down (W6D5: 8). As much as they are exchanges of information, the report times are times of sharing experiences. They are important for the Sisters.

Sr. Ellis: But I think it's a fact that so much can be taught to people through in theory but, you know it's essential to have some training, some background, some knowledge. But I think really at the end of the day the experience that you've gained and... looking at your experience, and discussing it with others and using it in a positive way, is the most important thing, I think, the overall most important thing. (Int. 5-3: 31)

Talking about experiences allows the Sisters to explore their feelings about patients and situations. It provides an opportunity for the Sisters to find new meanings in experiences and come to terms with difficult situations. In their everyday work, encountering death and dealing with the intimate "... most private aspects of people's lives" (Fagin and Diers 1984), this is necessary. "... [W]e need to go through it .. [...] and we see it and we try and talk." (Int. 5-3: 34)

Telling about experiences enables the Sisters to learn in and from their experiences. Sharing experiences is a "powerful way of clarifying confusion, identifying appropriate questions and reaching significant insights" (Knights 1985). In telling, the links and connections which the Sisters make between their present situation and situations they remember are revealed. When they tell about their experiences in practice, the Sisters are not detached: rather they remain engaged, concerned about what is going on. Often telling about practice brings with it a hint of the journey towards greater understanding of themselves and their nursing practice.

LEARNING WITH OTHER PEOPLE

Nursing is practice with people and the Sisters continuously learn from the people around them. Patients figure centrally; the Sisters talk of ward sisters, staff nurses, doctors, and family and friends as being influential. Perhaps understandably, these experienced Sisters mention a teacher only once. Three aspects of learning with people stand out in their accounts. The first is learning about ways of being a nurse and a person just by being with patients and other nurses. The second relates to the importance of being challenged and given responsibility yet being supported at the same time. And the third concerns the interconnection of the Sisters' practice and their life "outside".

Learning by Being With Others

Each of the Sisters told about people in their careers who had made a strong impression on them as nurses. What makes certain people influential is:

Sr. Grant: I think the thing they have in common is that they all have attributes that I would like to have myself. I admire them and would like to behave as they do. So in that experience .. In that way I've modelled myself on them. Although I think they were probably quite different sorts of people with different styles. They all had things that I particularly valued.

M.M.: Mm hmm. Have these people come along or been with you at particularly influential times in your life?

Sr. Grant: Um well because they were there it became influential. (Int. 7-3: 35)

The Sisters describe learning from how their ward sisters practised nursing: how they ran their wards, talked to patients, worked with the medical staff, coped with stress or created a caring atmosphere in which to work.

Sr. Jarvis: I know that she taught me an awful lot. She was from an intensive care background. And at this time I had never set foot in an intensive care unit in my training apart from head injuries which I'd hated. She showed me that the confidence and knowledge that she had gained doing intensive care and the intensive care course had helped her in a general ward situation.

And it had also given her confidence in dealing with medical staff. She wasn't prepared to just say, "They're the medical staff, they know best", and would leave it at that. She realized that the patient was the most important person. And she did whatever she could do to make sure that that patient was looked after properly. And if that meant going over the head of whomever was looking after them at the time then she would do it.

Her style was very different to what mine is now. I know that. But those sort of things that she taught me I've never forgotten. (Int. 10-3: 24-25)

The Sisters not only learned about concrete aspects of nursing practice, they learned ways of being nurses.

Being Challenged and Supported

Sometimes the Sisters were challenged to think about nursing in a different way.

Sr. Grant: [It was] at a time when I felt very disillusioned about nursing and was ready to call it a day. And I went to [the teacher] and said, "This is not for me, I'm going to call it a day". And she basically said to me in a quite sympathetic way, "Don't you dare opt out - After all the effort I've made?". [...] And, "If you're not happy with it, you change it. You do not leave." And in a very nice way. I came back and I realized what she'd said. "And how are you going to change it?" (Int. 7-3: 36-37)

The Sisters described influential nurses and doctors as being supportive.

Sr. Grant: Well I think perhaps the only person I can really remember being supportive in that situation was our senior registrar [...] Who himself was very organized and a good administrator, an interested administrator. We consulted one another. He always seemed to know what was going on. And I think between us, we worked out what our different roles would be. (Int. 7-3: 8)

Being supportive includes being respected and being helped to find a way of handling the responsibilities of the position. Most of the Sisters tell about feeling supported and challenged as a senior student or in their first staff job. Part of being supported is being challenged with responsibility, but having help to successfully handle it. Sr. Calder tells about her experience as a young staff nurse with a ward sister who was considered to be an 'ogre'.

Sr. Calder: Sisters were always around in those days. And she would come up and say to me, "Do you know anything about diabetics? What do you know about your insulin and all this jazz?" I said "Oh, what do you want to know?" And you know, "Well do you know where it comes from and Islets of Langerhans da da da". I can't remember all the specifics. "Oh" I said, "No". You know by this time, we did communicate and I mean she appreciated me and I appreciated her. "Right then." So she would rattle off something to me. And I thought "O.K.", standing up. And then we would have a diabetic [lesson at the handover report] "Tell me." She'd come to the first year nurse. And she'd ask [the students] a question about diabetes. And they wouldn't know. "Staff Nurse would you tell them?" And I

would tell them. And she'd only told me five minutes before.

[...] She made sure that I knew before she ever did that. But she did it. And then it made the staff nurse look better in the students' eyes. And I mean, I knew quite a bit of it but sometimes there were bits that I didn't know. But she had checked it all out that I did know. (Int. 3-3: 36)

Ward sisters and staff nurses who were supportive "inspired great confidence" (Int. 7-3: 37). They "gave [the Sister] the courage" to try (Int. 6-3: 36). They believed in the abilities of the Sisters to nurse, and to nurse well. Their standards were good, they knew their specialty and they "ran" a good ward.

Ward sisters who refused to let the Sisters take responsibility and who blocked involvement in care, stymied growth.

Sr. Ellis: [The ward sister] knew all about [the specialty surgical procedures], but she never shared that information. You ASSISTED her. She did the premed, she did the dressings, she did the doctors' rounds, and even as a staff nurse you assisted her with everything. And she'd be here from seven o'clock in the morning until midnight every day if she could. And so really in the end we were learning very little. And in her absence we were keeping the place going, really. You weren't making any decisions or changing anything. You were just keeping the place ticking over until she came back. We were frightened to let anyone go home in case it was wrong.

So, after I became a staff nurse and she'd retired I really sort of felt as if.... Although I knew how to run a ward basically, I didn't really know anything particular about the specialty apart from what I'd read in a book, or someone else had told me. So I think I felt as if I started from scratch and I've just learned from experience. (Int. 5-1: 19)

Supportive ward sisters set up situations to help the Sister become confident and to see new possibilities.

Sr. Jarvis: [...] I can remember [Sister] sitting down and chatting with me about what I was going to plan on doing, and conveying to me the sort of experience that she had gained from intensive care. And how she thought it could enhance what I was doing. (Int. 10-3:25)

All of the Sisters have worked with ward sisters who have recognized their potential and have challenged and supported them to realize possibilities the Sister herself has not yet seen. These ward sisters have shared themselves and their experiences with the Sisters.

Living and Learning

All of the Sisters have ways "not to take work home", but they recognize the intertwining of their experience in nursing practice with their whole life experience. Families and friends strongly influence the Sisters' learning. Like Sr. Aitkin's flatmate who helped her to get a different perspective on her practices (Int. 1-1: 29), and Sr. Baxter's granny who taught her about getting along with people (Int. 2-3: 12), friends and family members help the Sisters come to new understandings. What they learn in their life outside nursing impacts on their practice.

Sr. Inglis: I certainly feel bringing up two teenagers, I'd like to think makes me a bit closer to these youngsters. [...] You know I see both sides of it. They're young, they've got all these stresses in life, but nevertheless they've chosen nursing to come in to. It's a disciplined profession. So they jolly well have to work hard. [...] Yes. I think it gives you a good insight into how they tick. (Int. 9-3: 23-24)

And what they learn in practice impacts on their outside life.

Sr. Inglis: You see my husband would say I've become a much tougher person, harder. And I think I probably have.

M.M.: In what way?

Sr. Inglis: I think I probably would have given in an awful lot in our early marriage. And he would have always won the day. Now that might have come anyway, whether I had been a nurse or not. I think that might just have been experience doing that. But I can certainly stand my ground now. And I do it with doctors, with the hierarchy. And with visitors, if I have to. And with patients if I really have to. [...] And if a decision has to be made in the ward and it doesn't suit everyone, then that's too bad if it's the decision that I have really thought about. Because there's no way you're going to please everybody. (Int. 9-3: 24)

What the Sisters gain from people outwith nursing affects them, and therefore has the potential to affect their practice. Conversely, what the Sisters learn in practice affects them as people. This is particularly so in the case of learning from patients.

There has been little direct mention of how patients figure into learning as they feature so centrally as the main source of the Sisters' experience and thus are the primary teachers. Learning about the meaning of illness, and the character of people they care for are among the sources of the greatest satisfaction for the Sisters. "She [the patient] gives us a lot back, to us so I think you can learn a lot from how she's coping and her spirit" (Int. 6-2: 22). Knowing how patients help them to learn, the Sisters actively encourage the learners to find out how illness affects patients and what care is helpful.

[Sr. Aitkin] advises the student to "Talk to her about her symptoms ... You can read it in books, but talking with patients is the way you learn it". (W1D1: 4)

Being attuned to patients and their concerns enables the Sisters to gain from them, in understanding and satisfaction. The Sisters learn not only from their own experience, they also learn from the experiences of patients and colleagues. Learning with others is part of experiencing nursing.

CONCLUDING COMMENTS

For the Sisters, experience in everyday practice is the foremost source of understanding how to care for patients and run their wards. In everyday practice, they learn, whether or not they intend to. Learning is part and parcel of experiencing nursing practice. Noticing plays a special role in relation to experiencing. It produces an opening of possibility which allows for the movement in experience. Into the gap comes learning, which gives the movement its direction and influences the quality and quantity of change. Learning is much like the wind. It is impossible to grasp but its presence and influence are unmistakable.

Experiences take many forms, but characteristic of all is the involvement of the Sisters which allows them to grasp the meanings inherent in their practice and experiences with patients and others. Constant noticing, coupled with memory

and making linkages, enable the Sisters to come to "realize", to understand. Coming to realize is like the hermeneutic circle where parts are identified and understood, then the whole is grasped, causing different sense to be made of the parts.

In their practice, the Sisters are continually open to new experience. Their conversations are dialogues in which they listen and come to new understandings of what they hear and experience. Their actions work in much the same way, with their bodies becoming more skilled as they move through practice.

The Sisters' learning is much like a journey, one in which their openness to experience helps them along the way. The journey leads them to become experienced in practice, and to a greater understanding of themselves as nurses and people. It is easier to track the Sisters' journey when they are newly in a situation. Unfamiliar situations and new experiences lead to conscious reflection which is easy to grasp. It is harder to track subtle differences in a person whose experience and situational understanding is already complex.

It is difficult to say if the form of experience and learning has changed over the years among the Sisters. Certainly the focus of their experiences changes as time goes on. It seems likely that they have always been aware of what is going on in a ward and they have always noticed particularly. A clue to this comes from their awareness of the different facets of the characters of the ward sisters with whom they worked earlier in their careers. None of the people described by the Sisters as influential are 'cardboard' characters. The Sisters describe their current experiences with the same attention to salient details. Although they recognize themselves in less experienced nurses, they are no longer at that point. Their confidence and ability to handle situations have moved them beyond the others. What opens up through noticing and where they look for solutions to problems is different. They also continually seek new information. They seek the hearing of others that dialogue can bring. Their confidence removes the threat from many things which may once have been threatening. They enjoy their experiences and their journey.

This thesis has been something of a journey as we have explored the terrain of the Sisters' experiences and their practice, and investigated the flow of their

practising and experiencing. It remains now to complete this journey and to see what it tells us about the nature of everyday experience in nursing practice.

CHAPTER 9

SUMMARY, CONCLUSIONS AND BEYOND

INTRODUCTION

So far in this study, the everyday experience in nursing practice of 'experienced' surgical ward sisters has been uncovered and explored. In this chapter, I shall recapitulate the major themes which have been developed through the study and draw out some of their implications. Before moving on to that discussion, it may be useful to recall the origins of this research.

The original aim of the research was to explore the nature of everyday experience in nursing practice with a view to gaining an understanding of how that everyday experience contributes to the development of nursing expertise. I came to this research from the position of an educational administrator in nursing who, like others in my position, made administrative decisions and planned academic courses based on the common-sense understanding that nurses learned through their everyday experience in practice. Indeed, this common-sense understanding is such that the need for a certain number of months or years of "related clinical experience" is written into position descriptions and continuing education course admission requirements. Without the necessary experience, nurses are neither hired, nor admitted to courses.

However, everyday experience, possibly because it is so familiar, is usually taken for granted: it has not been the subject of systematic investigation. Perhaps it is not surprising then, that such experience is often accorded lesser worth than academic preparation as a source of knowledge and skills. This is particularly so in North America. Thus, with the understanding that nurses in the United Kingdom have a reputation for providing good clinical bedside care, and that pragmatic, practical experience is valued here, I chose to undertake this study among Scottish nurses.

It will be recalled that I originally sought to study nurses who were considered to be "expert" surgical nurses. I found, however, that there were difficulties with using the term, "expert": it was said to be "too American" and seldom, if ever,

used to describe nurses in direct clinical practice. Instead, the two Directors of Nursing Service agreed to identify "excellent, experienced" surgical nurses. They identified with ease ten nurses who met the criteria first used by Benner (1984) to identify expert nurses. Significantly, eight of the nurses were ward sisters; the other two fulfilled part of a ward sister role. Locating experience and excellence in clinical practice at this position is not unusual in the National Health Service. The ward sister is generally thought to be the "repository of clinical expertise" (Lathlean 1987, 16). This selection of ward sisters also may reflect the lack of clinical specialist positions in Scottish hospitals, as well as the relative lack of full-time, experienced staff nurses in the 'general' surgical wards. Although the recently implemented clinical grading structure has the potential to create alternative routes for clinical advancement, at the time the nurses were selected, Rogers and Powell's contention held true: the existing career structure in the NHS "... does not enable a nurse to retain a major clinical involvement or responsibility beyond the grade of a sister" (Rogers and Powell 1983).

With the selection of ward sisters as the experienced, excellent clinical nurses, an unavoidable question is raised: why is clinical practice invisible in the ward sister literature? As it was seen in Chapter 3, the teaching and management aspects of the ward sister role have been repeatedly studied, but the clinical role has been overlooked and their clinical practice taken for granted. I would like to suggest that the clinical expertise of the ward sister, while it may be acknowledged, is undervalued. This undervaluing, I will presently argue, is linked to the nature of knowing in everyday practice which remains, for the most part, hidden from view. Nurses in the United Kingdom are not alone in undervaluing everyday experience and knowing. I would suggest that everyday clinical practice and experience are taken for granted as readily in Canada and the United States as they are in Scotland.

Before moving to a discussion of the Ward Sisters' practices and the nature of their everyday experience, it may be opportune to recall the approach taken to the study, and why I found it to be a useful way to examine everyday, taken-for-granted experience.

In determining an approach to the study of a phenomenon, the decision is ultimately a philosophical one. Most of the studies which have considered nursing practice and learning in experience have been in the philosophical

tradition of Descartes and Husserl. In this tradition, the fundamental human situation is of a subject in a world of objects. An understanding of experience results from directing the mind towards that world or towards itself, towards its mental contents. In order to do this, Husserl suggests that we 'bracket' our everyday understanding. What this tradition overlooks, as Heidegger so aptly pointed out, is the everyday skilful coping in taken-for-granted experience. To use one of his examples: we are not aware of turning the doorknob, we are only aware of the doorknob when it sticks. When the doorknob sticks we attempt to un-stick it, and it is only when that does not work that we may need to think about the specific properties of the doorknob itself. This is the point at which Husserl begins, the point of contemplation. Heidegger argues that what needs study before the problem of knowing, is everyday being-in-the world, as "much if not most characteristic human activity is not guided by conscious choices, and not accompanied by aware states of mind" (Magee 1987, 260). It would follow then that much of everyday experience in nursing practice is overlooked and taken for granted because it is skilful coping in the midst of an ongoing situation. Unless a problem develops or a doorknob sticks, we remain unaware of the skills and knowledge essential to this coping. Thus, an approach following in the tradition of Heidegger may be a more fruitful way of examining everyday, taken-for-granted nursing experience.

In Chapters 2 and 3, I proposed that studies using hermeneutic phenomenology (cf. Gray-Snelgrove 1982, Benner 1984, Diekelmann 1988), seemed to be the most successful at capturing the complex, situational and relational nature of experience and nursing practice. Hermeneutic phenomenology, in focusing on the person in the world, dissolves the subject-object dichotomy and enables the background meanings in shared practices and language to become visible. Therefore, through the perspective of hermeneutic phenomenology, I examined the nature and meanings of the Sisters' everyday experience in nursing practice.

A problem which I have not altogether avoided in this study is the risk of overlooking the structural interdependence of the person and society (Giddens 1982). Focusing the analysis on the intersubjective nature of the experiences and the relationship between the Sisters and their everyday situation has partially, but not wholly, counteracted this potential of isolating the Sisters in relation to the institution and society. If the goal of this study was explanation an explicit connection with the broader social structures would be critical. However, as this

study seeks to understand the nature of everyday experience and what it means to be 'experienced', an explicit connection is of lesser importance. The Sisters' language and practices reveal the broader social world; special attention to this aspect must await another analysis.

In order to study everyday, moment-by-moment experience in nursing practice, I interviewed the Ward Sisters about memorable and everyday experiences and observed them in ongoing practice on the ward. The study was richly productive of insights about their nursing practice as well as about the nature of their everyday experience. It would certainly be possible to focus exclusively upon the nature of ward sister practice; it would also be possible to distinguish domains of practice and competencies, as Benner (1984) and others have done. Having a Canadian perspective on both British nursing and American nursing practice, it would also be possible to examine in depth, the differences in practice which we often overlook because the language, on the surface, is the same. I have examined all of these areas on this journey, but for the purposes of this thesis, the core of the empirical study is understanding the nature of taken-for-granted, moment-by-moment experience, and how it contributes to the development of expertise amongst 'experienced' ward sisters. Having said that however, the nature and context of that practice is crucial to the argument because experience happens only in the midst of ongoing practice.

Although nursing practice could easily become the foreground, for the purposes of the core of this thesis, it must remain in the background. But it cannot be overlooked or diminished. So before moving on to the discussion of experience, the core of this thesis, I will briefly review what the study revealed about the nature of the Ward Sisters' nursing practice.

BEING A SURGICAL WARD SISTER

When the Sisters' practice is viewed from the vantage point of everyday experience, it is revealed to be purposeful, caring, complex, multifaceted and patient-centred. In Chapter 6, I have described how the Sisters make the ward work in order to help individual patients towards recovery. As the section, "Helping Patients Towards Recovery", illustrates, the Sisters experience each patient within a temporal framework of their stay on the ward. As the Sisters organize or provide care directly to individual patients, their practices reflect an

understanding of the patients' experiences in the past, how they are in the present and what possibilities there may be for the future. The Sisters become adept at picking up on subtle variations in people's responses to recovery. They also become adept at creating complex goals for seemingly innocuous activities, such as eating or bathing, which actively assist the patient towards recovery. It is this complexity yet subtlety of goals and interventions which are not given the prominence they deserve in much of the current research literature on recovery from surgery (cf. Wilson-Barnett and Fordham 1982, Johnson 1984).

The Sisters orchestrate the care of patients by a largely junior and transient workforce. This is characterized in Chapter 6 as "Making the Ward Work". A commonly heard phrase amongst them, "Today's another day", expresses the temporality of their experience. The Sisters make the ward work, for the most part, on a shift-by-shift basis. The juxtaposition of their experiences, of the patients individually over time in the midst of the day-by-day experience of the work of the ward, is a source of creative tension. Their everyday practices reveal how this tension is played out. Their practices, which are replete with complex goals, much like Dewey's (1925) ends-in-view, are directed individually, yet are within the context of ensuring care for all the patients on the ward.

The Sisters' experiences and practices were revealed to be interlinked: they are contextual and relational. They are formed in and for the particular situations in which the Sisters find themselves. A number of examples in Chapters 5 and 6 illustrated, for instance, how the Sisters change their conversational approach to suit a particular patient, finely adjust their movements in response to the demands of a patient's wound or intervene with finesse when a junior medical or nursing staff member is running into difficulty. Upon close examination of the interview transcripts and field notes, a process of noticing, understanding and acting was found to characterize this relational and contextual nature of the Sisters' practices. This process, a key finding of the study, was also found to be the process of experiencing practice. It will be further discussed in relation to the nature of experience.

Although nursing practice provides the ground for the main thrust of the thesis, a few comments may be made about the view of practice revealed by this study. In the nursing practice literature, this study sits closely to Benner's work and to the ward sister studies. Thus it is to that work that we now turn.

A somewhat different pattern of practices was found in comparison to Benner's competencies. Although at least seven Domains of Nursing Practice (Benner 1984) could be discerned from the analysis of the Sisters' practices, the analysis did not proceed along the line of identifying competencies, roles and domains of practice. Instead, the Sisters' practices were better understood in relation to their experience of the stay of the patient and the day-to-day working of the ward. In addition, many of the Sisters' practices address more than one role or competency. For example, when the Sisters place a patient's bed in a particular position in the ward, they do it to meet the patient's individual needs, while at the same time seeking to effect a smooth delivery of care to all the patients with the work-force at hand. The approach of domains and competencies usefully illuminates the complexity of nursing practice, but I would argue that a taxonomic form cannot adequately capture the flow of everyday experience in nursing practice.

It was argued in Chapter 3 that many studies in the ward sister literature hold the ward sister role to be a complex one, yet individual studies focus on only one part of the role. Perhaps the most influential of the studies is Pembrey's (1980), in which she described the role of the ward sister in the management of nursing on an individualized patient basis. That role, she contends, consists of implementing the four stages of the management cycle in relation to each patient and each nurse. This study has shown that the Sisters' practices together form a complex whole which is centred on the patient. Rather than being a separate endeavour, the Sisters' management practices have been seen to be virtually inseparable from their practices concerned with helping patients towards recovery. Their practices concerned with helping junior nursing and medical staff to learn are similarly interlinked. This interlinking would seem to have important consequences for the development of the ward sister role and the education of sisters. Whilst the ward sister role may need to be enhanced from a management perspective (cf. Lathlean 1988) or for the purposes of ensuring adequate clinical education of students (U.K.C.C. 1986, N.B.S. 1989), the findings of this study indicate that the management and education components of the role should be strengthened only within a context of caring for patients. This study has shown the need to recognize anew the value of the expertise of experienced ward sisters. Their role in assuring the quality of care for patients and learning for students is crucial. The ward sisters manage the work of the ward, ensure the quality of care and help

junior staff to learn, whilst keeping the patients at the hub of all their endeavours.

Chapter 6, in particular, detailed how the Sisters practise in the midst of organizational constraints. Such everyday organizational experiences include: frequently being a safety net for a transient and junior work-force; the difficulties in meeting the standard of care which they consider the patient to "deserve" within a complex hospital organization with often inadequate staffing; and having authority within the ward, but not perceiving themselves to have it within the organization. These organizational constraints echo the "extreme work overload, staff shortages, a preponderance of inexperienced nurses, high staff turnover", found to be barriers to expert clinical practice in the AMICAE study in California (Benner and Wrubel 1982) and reinforced recently by Gruber and Benner (1989). Yet in the present study, "excellent, experienced" Scottish ward sisters were found to be practising expertly, keeping the patient at the centre of their care and helping junior staff to learn. Although they were concerned about the quality of care, they were not too busy for caring.

Although relevant findings with which to specifically link this study to the North American context are lacking, I would suggest that the physical environment and the authority of the ward sister may be two important factors to consider in comparing nursing practice between the United Kingdom and North America. In the study hospitals, the open architecture enables the Ward Sisters to monitor and attend to the patients, and supervise students in different ways than may be possible in wards where the nurse has to enter individual rooms before being able to see or communicate with the patient.

The clinical authority of the ward sister was one of the most puzzling aspects to me as a Canadian, of understanding her practice. There seems to be a marked difference in the location and exercise of authority between the North American system of nursing as reported in the literature and the system within which the Ward Sisters work. The Sisters seem to have more authority, possibly because of their historically derived position as head of the ward. This is bolstered by their clinical knowledge and expertise. Perhaps reflecting the differences in the societies, nurses in the North American system lack that entrenched, positional authority. American nurses, particularly primary nurses, operate more from personal authority: from their clinical knowledge and knowledge of the patient

(Prescott, Dennis and Jacox 1987). There were marked differences between the amount and nature of interaction between doctors and nurses reported in the U.S. literature (Schilder 1986, Katzman and Roberts 1988) and the more frequent interaction which I observed amongst the Ward Sisters and the residents, registrars and consultants. Differences such as these would be worthwhile exploring should the opportunity present itself to compare in a comprehensive way, this study's material to Benner's (1984) domains and competencies.

The discussion thus far has revealed some of the complexity of the Ward Sisters' day-by-day nursing practice. I have suggested that their everyday practices are inseparable from their experience of practice. Indeed, I would suggest that for these "excellent, experienced" Ward Sisters, being a surgical ward sister can be characterized as being attuned to experience: the experience of patients, the experience of those with whom they work and their own experience. Being attuned to experience also appears to be the way in which the Sisters develop expertise through moment-by-moment, day-by-day practise. It is to experience and experiencing practice that we now turn.

THE NATURE OF EVERYDAY EXPERIENCE

When experience is referred to in the research literature, such as the literature on learning in experience, it is usually taken to be a non-problematic, static, spatial entity. Experience is considered to be something which a person has and can give meaning to, something that can be reflected upon retrospectively. Even in the phenomenological studies, with few exceptions (cf. Gray-Snelgrove 1982), experience is treated as if it were non-problematic, to be examined only for the meaning it contains (the meanings in lived experience). When the focus of the studies is on everyday practices (cf. Benner 1984), the meanings in the experience are revealed as being relational and contextual. However, the nature of experience itself is not usually considered to be problematic, and has not been the focus of attention.

In this study, the focus of attention was directly on the nature of experiencing everyday practice. In the field notes and interviews, the Sisters' ongoing moment-by-moment experiencing, as well as retrospective experiences were recorded. When these field notes and interviews were examined, experience was not found to be as static nor as simple as it is usually made out to be. It was revealed to be

fluid and complex, closely linked to moment-by-moment nursing practice and already imbued with meaning.

Time plays an important part in ongoing experiencing. By looking at moment-by-moment nursing practices and by examining the links among past experiences and projections for future practices, experience was found to be always in a state of flux. It becomes evident that previous experience is linked to experiencing in the present, which in turn is geared towards possibilities in the future.

The Sisters' experience was found to take many forms, ranging from intensive, vivid and memorable, watershed experiences, through the less emotional, resonant experiences of their accounts, to the most prevalent, taken-for-granted experience which accompanies most "usual", everyday practice. Sometimes they could identify "an experience" and tell about it as such, but more frequently experiencing was vague and elusive, and expressed by the Sisters as "just experience". Sometimes, experiences were immediately meaningful; what was expected was not found and the Sisters' understanding of a situation was disconfirmed. More frequently however, the experiences were subtle, with meanings gradually unfolding over time. These more subtle, unnoticed experiences often served to extend, enrich and confirm understanding. Sometimes, after a period of time and experience, the Sister would notice a change in her understanding and "suddenly realize". Also, as the Sisters gained experience, different meanings in previous experiences would often emerge. Experience is not static in the past: experiencing comes from the past, is in the present and is geared towards the possibilities of the future.

This variety and complexity of experience is notable on at least two counts. In studying nursing practice from the vantage point of experience (cf. Benner and Wrubel 1989), it would seem to be important to take into account the nature of experience and the view of practice afforded by different types of experience. For example, the emotion which is evoked by many of the examples in Benner and Wrubel's important book may stem, in part, from the paradigm cases which provide the basis for much of the discussion. These paradigm cases are themselves infused with emotion: they are significant, watershed experiences for the nurses involved. The impression of nursing practice thus portrayed, while important, is somewhat skewed as it gives insufficient attention to the nursing practice which lies outwith "paradigm" experiences. Within the context of the

present study, by contrast, the meanings of the Sisters' current practices cannot be adequately understood unless the various forms of that experience are appropriately recognized. This is highlighted by the fact that as they become more experienced, the Sisters have fewer watershed experiences. At the same time, their practice does not remain static: it continues to develop and change.

Taking the complexity of experience into account is important too, when considering how learning accompanies experience. For the Sisters, becoming experienced surgical nurses seems to be a complex process, linked to their moment-by-moment practising. They seem to be learning all the time. Just as experience appears to be fluid and elusive, so too does learning in everyday practice. Learning does not seem to be as discrete a phenomenon as various experiential learning models (cf. Kolb 1984, Boud, Keogh and Walker 1985) would suggest. Instead, learning could be said to accompany experiencing in everyday practice and as well, to be an outgrowth of experience. Being attuned to experience is the process, through which the Sisters develop expertise.

BEING ATTUNED TO EXPERIENCE

The continuous interplay between practice and experience which emerged from the Sisters' accounts and observations of their practice was explored in earlier chapters. I wish to suggest that for the "excellent, experienced" ward sisters in the study, being attuned to experience is at the centre of their everyday experience in practice. Being attuned to experience carries with it a sense of openness to experience, a dialogue with others and with oneself and an understanding of knowing which goes beyond theoretical knowledge. Gadamer puts it well.

The nature of experience is conceived in terms of that which goes beyond it; for experience itself can never be science. It is in absolute antithesis to knowledge and to that kind of instruction that follows from general theoretical or technical knowledge. The truth of experience always contains an orientation towards new experience. That is why a person who is called 'experienced' has become such not only through experiences, but is also open to new experiences ... [T]he experienced person proves to be ... someone who is radically undogmatic; who, because of the many experiences he has had and the knowledge he has drawn from them is particularly well equipped to have new experiences and to learn

from them. The dialectic of experience has its own fulfilment not in definitive knowledge, but in that openness to experience that is encouraged by experience itself. (Gadamer 1975, 319)

Like Gadamer's "radically undogmatic" person, the Sisters are continually open to new experience. They are open to their own experience, the experience of the medical, nursing and other staff on the wards, and most importantly perhaps, to the experience of the patients. In Chapter 8, that openness and the effect on their learning was detailed. It was suggested that the Sisters continually keep their own practices and understanding in question, and develop ways to prevent becoming complacent and deaf to their experience.

Constantly noticing, the Sisters continually test and revise their understanding of the patient, the nursing care and the situation. Being attuned is a reflexive, comparative and connective process, through which the Sisters continually expand their capacity to notice, understand and act. The Sisters develop expertise in practice by being attuned to experience: it is the way in which they become "experienced". At the same time, I would argue, for the Sisters being attuned to experience is the ongoing process of practising nursing. And this process, I would suggest, can be characterized as noticing, understanding and acting.

Noticing, Understanding and Acting

The process of noticing, understanding and acting, because it is the process of practising, of ongoing experiencing, is usually transparent to us. The constituents of the process cannot be readily separated and analysed. Noticing, understanding and acting are inextricably intertwined in everyday practising. Being in a particular situation, the Sister notices salient aspects of that situation, understands what they mean and acts. For instance, mid-morning she may glance around the ward, notice how the patients are faring and how the nurses are progressing with their work. Depending upon what she sees, she may smile and acknowledge the progress, help a nurse reset her priorities, help a patient back to bed, or any number of other actions which make the ward work in such a way that patients can be helped towards recovery. The Sister's understanding comes primarily from experience in previous, similar situations: it makes noticing possible. In turn, noticing and understanding are made possible because the Sister is acting: she is already in a particular situation. And finally, noticing, understanding and acting

are all made possible in the first instance by the Sisters' involvement, commitment and care. Chapter 7 details this process and its links to expertise.

There is a qualitative dimension to this process. Just as the Sisters notice in the situation, they can fail to notice. It seems that fatigue, a certain lack of involvement, or failing to understand meaning in the situation all inhibit noticing. Noticing seems to be enhanced when the Sister is confident in her own practice and it becomes transparent to her; she can broaden her focus of attention. No longer self-conscious about her own performance, the Sister can attend to the effects of nursing actions on the patients or ward situations. Noticing is also enhanced through a deep understanding of possible meanings inherent in particular situations.

Understanding is informed by both practical know-how and theoretical knowledge. It is understanding in and of a context. Although many meanings are inherent in any situation, the Sisters understand some aspects of the situation to be more salient than others. As the Sisters gain understanding of a situation, they are able to tune in on the more important aspects of similar situations. A failure to understand, or to misunderstand the meanings in a situation is also possible. The Sisters' reputations as excellent practitioners attest to the reliability of their understanding.

Like noticing and understanding, there is a qualitative aspect to acting. The Sisters' timing, pacing and suiting of their actions to particular situations derive from what they understand and how they notice. Their actions can be appropriate or inappropriate in the circumstance. Confidence seems to be a factor, both in their ability to act in certain circumstances, as well as affecting how sure and fluid their actions are. The process of noticing, understanding and acting is a holistic one; the inseparability of body and mind is readily apparent. The Sisters' comportment, their tone of voice and their touch all play a part in experiencing and practising.

The Sisters are noticing, understanding and acting all the time. It is not just the big things in practice which are included. Indeed, it is in the little things: noticing the expression on a patient's face during a dressing change, understanding the meaning of the expression for the patient in relation to the meaning of the wound (and perhaps the pain), and adjusting action, changing the pressure or the

timing of movements. The thoughtful, small practices and adjustments to practices which may seem insignificant or simple often transform the quality of care for the patient and the ward from adequate to excellent. In fact, the little things are not "little" at all. They may be commonplace and are often taken for granted by the Sisters, but they are fundamentally important to the patient and to the quality of care. It is through noticing, understanding and acting on the "little things" as well as the big that the Sisters' practices are contextual and relational.

Questions persist concerning the accuracy or "rightness" of the Sisters' understanding and actions. Do the Sisters improve their understanding and skill as they practise, or do their actions merely continue misconceptions or misunderstandings? In this type of interpretative research, issues of judgement cannot be avoided. Connected to them are issues regarding the expertise of the researcher in the clinical area; these were discussed in Chapter 4. Suffice it to say here, that as an informed but non-expert surgical nurse, I was unable to judge whether or not the Sisters practiced with the most current knowledge or intervened in the most effective way possible. However, I did observe, as did they, the effects of their actions in individual situations and was attuned to discrepancies. Evident amongst all of the Sisters was their openness to re-evaluating their own knowledge and practice. They were as open to receiving information from junior nurses as they were from senior consultants and the research literature.

Being attuned to the "little things", on a moment-by-moment basis, the Sisters seem to continually extend and refine their understanding, the ways in which they notice and how they act. They continually keep their practice in question. The Sisters appear to be in a continual dialogue, which is not always verbal, with their practice and fellow practitioners.

With the current emphasis on the importance of ensuring a "systematic approach to decision-making and planning nursing care" (McFarlane and Castledine 1982, Boore, Champion and Ferguson 1987, Ames and Kneisl 1988), the question is inevitably raised about how the process of noticing, understanding and acting relates to the nursing process. Just as the stages of the nursing process might describe any problem-solving process, so noticing, understanding and acting might describe any process of practising. It needs the context, intention and knowing of the nurse to depict practising nursing. However, unlike the

nursing process, which is usually described as a staged, or circular process in which the activities are performed in sequential order, the Sisters notice, understand and act virtually simultaneously. They engage in this process even while they may be systematically planning nursing care in a broader sense. Recent criticisms about the nursing process, that its rational deliberation does not reflect the actual planning and decision-making processes of experienced nurses (cf. Tanner and Benner 1987) are supported in this study. The decision-making of the Sisters could be said to be characterized by the intertwined, frequently intuitive process of noticing, understanding and acting.

Thus far I have suggested that everyday experience is more complex, yet subtle than it is usually given to be. It is not static, but it is linked to ongoing practices and through them with time. Practising and experiencing have the same non-linear temporal character. There is a continual interplay of the past, the present and the future in ongoing practising. It would appear that the Sisters become "experienced" and develop expertise by being attuned to experience. Being attuned to experience is constituted by an inextricably intertwined process of noticing, understanding and acting which is made possible through a stance of involvement and care. For the Sisters, noticing, understanding and acting is the process of ongoing practising, and as well the process of experiencing. This process cannot be adequately understood unless there is appropriate recognition of the character of knowing which is in practice and developed through being attuned to experience.

Knowing-in-practice

By focusing attention on taken-for-granted, everyday experience, we have seen its complexity and interconnection with ongoing practising. The Sisters are seen to practise confidently, smoothly, thoughtfully and expertly. Consultants, patients and other nurses have confidence in their practice and knowledge; they continually teach junior staff about patients and how to care for them; they handle a wide range of complex situations, tailoring their practices to the situation. The Sisters' moment-by-moment practice indicates that they are knowledgeable practitioners, continually deepening, refining and extending their knowledge by being attuned to experience. The knowledge they are extending in their everyday practice is, I would suggest, knowing-in-practice.

It may be recalled that in Chapter 2, the distinctions of theoretical, or formal knowledge and practical knowledge were made. I argued there, and in Chapter 4 that conventionally, knowledge and practice are understood to be two separate entities which may be joined or integrated. I suggested that studying everyday practices from a view that looks beneath this subject/object, knowing/behaving separation, would enable the relational and contextual nature of experience and practice to be revealed. As we have seen, the process of noticing, understanding and acting was identified, as was the knowing which is already there in the Sisters' taken-for-granted, everyday practices.

In this study, nursing practices have been seen to be ongoing, in the background. They constitute the Sisters' everyday, pragmatic activity and language. These practices make the Sisters' actions count as nursing. Everyday practices cannot be understood as actions consciously performed by intentional actors, nor can they be understood as activities in a behavioural world. Likewise, this multitude of background practices and meanings cannot be isolated or extracted in the form of theoretical formulations or knowledge, even "background knowledge". Indeed, this everyday, taken-for-granted level of pragmatic activity "cannot be understood as *knowledge* at all" (Dreyfus 1983b). Practices cannot be considered rote actions, but neither can they be thought of as knowledge per se. But that is not to say that knowing is absent from practice. Practices could well be considered to be knowledgeable actions in and of a specific context.

In Chapter 2, the distinction between theoretical knowledge (knowing-that) and practical knowledge (knowing-how) was discussed. Theoretical knowledge is commonly set up as the antithesis of practical knowledge: theoretical, or formal knowledge is abstract and decontextualized; practical knowledge is always in and of a context. In discussions of knowledge in nursing (cf. Meleis 1985), practical knowledge is overlooked completely; the only recognized form of knowledge is theoretical knowledge.

In the conventional view, it has been argued, theoretical knowledge is seen to be separate from practice. Practice, in this view, is usually understood to be something of a behavioural world or an arena of action. Professional practice (cf. Schön 1983) consists of performance in a range of professional situations and the preparation for performance. A central question within this view concerns the process through which theory can be integrated with practice. It is usually

proposed in this conventional, albeit ideal view, that nurses should work from a "scientific" base, using practice theory. Theory, which develops through research, would guide practice through identifying the focus, the means and the goals of practice (Meleis 1985, 31).

It would follow that, if theoretical knowledge is used in practice, then theory should be able to be discerned in practice. Taking the conception of theory to consist in or be "represented by the general form of explanation of a number of cognate events or phenomena", Clark suggests that if theory is to be considered as being used or applied by practitioners, then it must be capable of clear explication and identified in practice.

... theory in its abstract form must always be discernible to at least one observer if it is ever to be identified as a theory, and the explanations be understood as other than an accidental series of similarities. (Clark 1989, 34)

In this study of the Sisters' everyday experience, it was impossible to discern theoretical knowledge or theory in an abstract form from observations of their practice, or from their accounts. But that does not mean that the Sisters do not have knowledge of theory or may not have originally learned some of their practice with the help of theoretical knowledge. Essentially, theoretical knowledge which they might once have had in the abstract form is no longer decontextualized and atemporal: it is embedded in the practical context. It has become part of knowing-in-practice. Indeed, theoretical knowledge is only visible in many situations because the Sisters are having to either explain or account for their practices. And even in these circumstances, knowing is seldom, if ever, expressed as acontextual, atemporal theory. The knowing only has its particular meaning because of the context.

Two approaches which run somewhat counter to the prevailing view that theory directs practice are offered by Schön (1983, 1987) and Freidson (1986). They both acknowledge the effect of the context of practice on the practitioner's knowledge. However, the inability to discern theoretical knowledge in the Sisters' practices suggests that Schön's (1987) argument that professionals operate from the basis of an interpersonal theory-in-use is insufficient for explaining the configuration of knowing and practice in particular situations. The Sisters' practices did not appear

to emanate from a theory, be it tacit or explicit. To suggest that they do negates the importance of the context in forming (and transforming) knowing.

In his discussion of the reflective practitioner, Schön (1983) proposes the concept of knowing-in-action, which he uses interchangeably with the term, knowing-in-practice. His concept of knowing-in-practice/knowing-in-action differs markedly from the notion, knowing-in-practice in this study. Schön's concept refers to the knowing of the regularities within all of a practitioner's practice, his "repertoire of expectations, images, and techniques". He suggests that the practitioner possesses this knowledge and uses it in the action world. This subjectively held body of knowledge can become increasingly tacit, spontaneous, and automatic; when it does, Schön suggests, the practitioner can "overlearn", and become selectively inattentive to phenomena that do not fit the categories of his knowing-in-action (Schön 1983, 60-61). The categorization of knowing-in-action suggests that it is a form of subjectively-held knowledge which is used as a template in action situations.

While it recognizes the importance of the context, Freidson's (1986) suggestion that theoretical knowledge is transformed into working knowledge, while useful, is also flawed. Freidson uses Kennedy's (1983) notion of working knowledge, an organized body of knowledge which is subjectively held and used in practice. However, this approach, like Schön's, maintains the separation of the knowing person and the world of practice. This separation was not found in this study. The Sisters' ongoing, taken-for-granted practices were not found to be separate from themselves, nor separate from the specific contexts in which they happened: their practices both formed the situation and were formed by the situation. Much of the time, the Sisters could not be said to "hold" and "use" knowledge: their knowing was already in their practices.

The Sisters' knowing-in-practice was found to be similar to practical knowledge, which Dreyfus (1980) suggests can be identified in everyday practical activity. However, it is proposed that there is a subtle, but important difference between knowing-in-practice and practical knowledge. For the purposes of clarity and illustration, practical knowledge is usually set in stark opposition to theoretical knowledge. This is understandable, given the elusiveness of practical knowledge and the concomitant difficulty in creating an adequate depiction of it. Practical knowledge, it was suggested in Chapter 2, has been variously described as

intuition, embodied intelligence or practices (Dreyfus and Dreyfus 1986). The conceptual inconsistency of Benner's (1984) six areas of practical knowledge further illustrates the difficulty of describing practical knowledge. I would like to suggest however, that while the delineation between practical knowledge and theoretical knowledge may be a useful and necessary one, treating them in a dichotomous manner does not adequately deal with their interconnection in the midst of ongoing practising. This interconnection in practice is best characterized as knowing-in-practice.

In their everyday practices, the Sisters did not seem to be using theory as Benner suggests, to tell them "where to look for legitimate concerns and what constitutes legitimacy" (Benner and Wrubel 1989, 20) but theory was not absent from their practices. As the Sisters took on board formal, theoretical knowledge, the contextualization of that knowledge by means of their practical knowing created new knowing-in-practice.

In most of their everyday practices, the Sisters' formal knowledge was hidden, like the brandy in a brandy fruitcake which can be tasted but cannot be extracted in the form in which it went into the mixture. Like the brandy in the fruitcake, formal knowledge is only a small part of the whole of everyday practice. Also like the brandy, it is transformed in practice from something separate and discrete to something which is united with its context. The Sisters' knowing is specific to a situation and is revealed through the situation. And as the situation changes, on a minute-by-minute basis, so does the configuration of knowledge, and indeed the character of knowing. In responding to the needs of patients and the demands of the situation, the Sister may extend and create new ways of knowing in noticing, understanding and acting.

The evidence in this study suggests that in day-by-day, moment-by-moment practice, the knowing with which the Sisters practise expertly, the knowing which characterizes the quality of their noticing, understanding and acting and which develops by being attuned to experience can be called *knowing-in-practice*. The Sisters' knowing-in-practice is imbued with theory and practical knowing, but it is knowing in a context: theory cannot readily be discerned. Already a part of everyday, ongoing pragmatic activity and informed by theoretical knowing, knowing-in-practice is at the same time, more subtle and encompassing than the

separate notions of theory and practice. Theoretical knowledge and practical knowing are already integrated in practice.

Developing Knowing-in-practice

In the same way that the Sisters' knowing-in-practice develops, so does their capacity to notice, understand and act in ways tailored to the individual patient and the ward. I have suggested that knowing-in-practice develops by being attuned to experience. Being attuned to experience is an ongoing thoughtful, complex, multifaceted and reflective process through which the Sister herself grows and changes as her practice develops: she becomes "experienced". This happens, as it has already been said, during moment-by-moment, day-by-day practising with patients and others on the ward (and outwith the ward). Before moving into a more abstract level, it may be useful to begin with some features of the Sisters' experience through which their knowing-in-practice was encouraged and enhanced.

As might be expected, for all of the Sisters, the patients emerged as the primary source of learning about clinical care. From the patients they learn about illness, the process of recovery, the meaning of being ill and the effects of their own practices. Patients are the most meaningful constituent of the Sisters' milieu.

Common to all of the Sisters is a confidence about their abilities to notice, and a sureness of action. Confidence does not just arise from developing knowing-in-practice, it also enables its development. Because of their confidence, the Sisters were able to act in situations, which in turn presented opportunities for developing new ways of noticing, understanding and acting. Their confidence was also inspiring to others, and again set up opportunities for new experience. Although they are confident in their understanding of a wide range of situations, the Sisters are not complacent and consistently keep their practice and their understandings open to question. They confirm and extend their understanding, their actions and how they notice through a process which is much like a dialogue with their own practice. This dialogue is part of being attuned to their own and to others' experience.

Important to all of the Sisters were times in their experience in which they were given responsibility with concomitant support from doctors, ward sisters or staff

nurses. Having responsibility with support seems to be key in developing confidence. It engages the nurse in the situation and engenders the commitment and involvement required to take action which in turn, opens new ways of noticing and understanding. A particularly important time for most of the Sisters to have responsibility with support was in their senior student or first staff nurse position. The role of responsibility in spurring-on learning is also a recurrent theme in research on learning in everyday experience in other fields (Rossing and Russell 1987, Burgoyne and Hodgson 1983). Exploring the meaning of having responsibility with support at different times in nurses' careers would seem fruitful, particularly with the introduction of new educational programmes under Project 2000.

These features of the Sisters' experience point towards the relational and contextual nature of being attuned to experience. Learning occurs in the midst of practising, in the midst of experiencing.

It was suggested that in the conventional view, theory is derived from systematic observations of practice, or developed outwith the practice milieu and then matched to, or applied in practice situations by nurses. The corollary of this view is that, in order to improve practice, the nurses should reflect on their experiences, bringing theory into this re-examination. In reflection, the nurses would not only gain a new perspective but also acquire new theoretical knowledge which can be applied in practice.

Conventional discussions of learning from experience mirror those on integrating theory and practice. Experience and learning are held to be separate entities, awaiting connection through a process in which action and reflection are in some sort of a dialectical, staged or circular relationship. In the reflection phase of experiential learning models, individuals reflect on entities which somehow have been abstracted from periods of experience or action. Through this process, new theoretical formulations are created, and then tested out in new experiences. This feature, common to all of these models, overlooks three things which have been found in this study: one, that ongoing practice is imbued with the thinking characterized by Clark (1989) as "the fluid, unlogical, intuitive, expressive and erratic character of ordinary thinking and problem-solving"; two, that people are experiencing all the time, including times of reflection; three, that knowing-in-

practice can be extended and developed without even reaching conscious awareness.

This last point, the extension and development of knowing-in-practice in the midst of everyday taken-for-granted experiencing is perhaps where this study differs most from other studies which address the extension and development of practice knowledge. This takes us back to Heidegger's doorknob. Unlike other studies (cf. Benner 1984), which suggest that experience happens when the doorknob sticks and there is an active refinement of preconceived notions and expectations about the nature of doorknobs, this study has found that the Sisters are experiencing all the time. Even when the doorknob does not stick, every time they open a door their hands feel the doorknob and gradually, over time, they come to feel what normal doorknobs feel like and how easily or stiffly doorknobs turn. Thus, when the doorknob sticks, experience has already given them a scale upon which to weigh stuck-ness. While the doorknob provides a simple example, the Sisters, I would suggest, become attuned to such things as the sounds of a ward, the look of pain and the smell of wounds through a similar process.

The suggestion that some knowing-in-practice develops imperceptibly raises questions about how practitioners' ways of working are depicted. For instance, Clark (1989) proposes, in respect to practitioners in community and social work:

I have described the practitioners' way of working as practical theorising. While being obviously practical in character, this process does also merit the appellation 'theorising' because it entails classification, the search for patterns and regularities, and above all the business of practically adequate explanation and prediction. It partakes therefore of the essential characteristics of theoretical knowledge. It is emphatically not the mechanical application of inert facts, but represents the intelligent use of complex and disparate knowledge at all levels. (Clark 1989, 230)

This idea of searching, connecting and making sense of regularities (and appreciating differences) in everyday practising, which Clark names practical theorizing, is similar to what Benner calls extending knowledge through interpretive theory. It is explaining in a way which attends to the local, particular, and specific whilst maintaining the meanings in context (Benner and Wrubel 1989). She suggests that expert nursing practitioners work in this way. I would

agree that the Sisters do work in this way a great deal of the time, but not all of the time. That is not to say that they do not practise expertly; rather, it is to say that practical theorizing does not completely describe how the Sisters work.

Benner and Wrubel go on to suggest that practice and theory have the possibility to exist in a dialogical relationship, with theory framing the questions and guiding the practitioner where to look and what to ask, and clinical practice, because of its complexity and variety, being itself an arena of knowledge development. Both Clark and Benner and Wrubel rightly propose a different relationship between theory and practice, one in which practice is primary. However, the word, "theorizing", to describe what practitioners do, is not without its problems. The word theory is usually associated with academic and formal knowledge. While there may be benefits to using it in describing practitioner action, there is a risk that the word may inadvertently bring with it the conventional associations and expectations of theoretical knowledge. This is of particular concern if it perpetuates the understanding that the scales with which knowledge is to be weighed must be those of formal or theoretical knowledge. What is unique about knowledge embedded in practice may be obscured.

Surgical nursing, because of its inherently practical and kinesic nature, the "disparate knowledge at all levels", includes a goodly proportion of knowing "in the fingertips" and understanding the meanings of fine gradations in smells and sounds. Neither term, practical theorizing nor interpretive theory, normally brings such knowing to mind. So much taken for granted, this knowing does not often come into descriptions of "experiences" or "paradigm cases". It begins and remains tacit, unsayable and intuitive. It is "absorbed" or "picked up" in ongoing experiencing. Inasmuch as the Sisters are attuned to the knowing which can be more readily articulated, they are attuned to the knowing which is tacit and intuitive.

Being attuned to experience encompasses both reflection and action. It is not atheoretical, but the complexity of experience suggests that knowing-in-practice is developed in a number of ways. By separating experience and learning, such as happens in experiential learning models, the ongoing "picking up", continual comparison and dialogue with practice which can occur in the midst of ongoing experience in practice is omitted from the understanding of learning. Being

attuned to experience points towards this ongoing reflexiveness in everyday experiencing.

THE PRIMACY OF EVERYDAY EXPERIENCE IN PRACTICE

This study began from a concern that there was something happening in nurses' everyday experience which not only enabled them to care for patients, but also contributed to the development of expertise. Upon examination, the taken-for-granted practice and experiences of "excellent, experienced" ward sisters, were found to be rich, complex and imbued with theoretical and practical knowledge. Through the process of practising, noticing, understanding and acting, which stems from a stance of involvement and care, the Sisters are attuned to experience and continually develop their knowing-in-practice. This study shows the wealth of knowledge with which the Sisters practice and the value in its development of being attuned to everyday experience.

Thinking of everyday practising as a process in which nurses can continually broaden and deepen knowing-in-practice, opens the way to thinking of the nurse as a knowledge worker. Until recently, nursing has not been thought of as a cognate discipline. Witness the difficulty nursing has experienced in gaining a secure place in higher education in the United Kingdom, and the length of time it has taken the profession to formally recognize the role of knowledge in practice. Project 2000 (U.K.C.C. 1986) has only recently proposed that the new practitioner would be "a knowledgeable doer". If we are to understand the nurse to be a knowledge worker then a much broader sense of knowledge must be contemplated.

At present, the legitimate knowledge in nursing curricula is formal knowledge, with knowing-in-practice relegated to informal discussions on the ward or as a subordinate part of theory courses. This is no less the case in North America (Diekelmann, Allen and Tanner 1989) as it is in Scotland (Darbyshire pers. com. 1990). This state of affairs is due, in part, to the fact that nursing has not systematically engaged in the development of clinical knowledge through "documenting, conserving, and enhancing the unique knowledge of the experienced clinician...." (Benner and Wrubel 1982). To realize the primacy of practice, clinical knowledge has to be systematically developed.

If knowing-in-practice is to be captured, everyday situations in nursing need to be written down. Writing puts practice in an enduring public space. Descriptions of everyday nursing practices would include their temporal nature, the particulars and the mixture of thinking and doing. Even though only a fraction of the richness and nuances of practice can ever be communicated, writing about practice in narrative form reveals far more than the skeletal form of theoretical knowledge.

In an oral culture such as nursing, clinicians are frequently not used to writing about their practice. If the Sisters in this study are any indication, nurses are not even used to talking about their taken-for-granted practice in detail. And as this research shows, much of nursing practice will not be communicated in writing, or told about as memorable experiences in interviews. It is passed on in gesture, precept or by incidental conversation to junior nurses. If this knowing is to be captured, innovative approaches may need to be devised. However, the fact that knowing-in-practice is often ephemeral does not diminish its importance.

A powerful rationale for encouraging experienced nurses to name and describe their taken-for-granted practices is that the process brings hidden practices to light. Although knowing about them may not prompt the nurse to change her practices, she sometimes gains a new appreciation of how she works. She can also then point out these invisible practices to junior nurses. In this way, experienced nurses are better able to help junior nurses notice salient aspects of a situation, make comparisons and links and explore new ways of acting.

The language about everyday experience in nursing practice, as well as opportunities for communication about it, need to be enhanced. This is not only to improve communication amongst nurses and within health care organizations, but also to communicate the value of nursing practice by knowledgeable, experienced, excellent practitioners to the wider public. Nurses need to be able to communicate the complexity and character of the crucial, yet often taken-for-granted "little things" in a way which acknowledges their importance to the quality of health care.

If nurses are to be understood as knowledge workers, the range of approaches which can be taken to develop ways of knowing must be acknowledged: from formal inquiry, to practical theorizing, to picking-up and absorbing. If the

complexity and range of everyday experience is recognized and valued, then the different ways of being attuned to experience have a better chance of being acknowledged.

The development of knowledge has conventionally been thought to be the province of researchers and higher education. Usually in nursing, theory is taught in the college or school and the student, the integrator of theory and practice, is expected to apply it in the practice situation (Alexander 1980, Melia 1987). Alternative approaches are being developed in some problem-based learning curricula and nursing staff development programmes (cf. Dick 1983) in order systematically to provide relevant theory to nurses in the clinical area where and when they need it to augment their knowing-in-practice. The Sisters are, in fact, doing this informally as they help students learn to care for patients. If practice and knowing-in-practice are indeed at the centre of nursing, then educational programmes need to reconsider where and when theory would most fruitfully be available to enhance the development of knowing-in-practice.

This study suggests that experience spans all situations. Being attuned to experience, the Sisters act, understand and notice, comparing similarities and differences in their own understanding and experiences, no matter where they occur. The notion of "transfer of learning" (cf. Bigge 1982, Alexander 1980) which has arisen as a way to make a theoretical bridge between theory and practice situations for learners is cast in a new light. Rather than being an issue of generalizability, knowing across situations may hinge more on the ability of nurses to recognize similar aspects among different contexts, understand their meaning, make comparisons and connections, and have the confidence to act.

The importance of recognizing experience in everyday practice has special relevance for the ongoing development of clinical nurses. Although current plans for continuing education (cf. U.K.C.C. 1990) acknowledge the need to legitimate experienced nurses' already-held knowledge, few higher education courses for experienced nurses are designed to strengthen clinical know-how. Most courses presuppose clinical knowledge and focus on the addition of theoretical knowledge. It is suggested that another approach is required, one in which the clinical knowing-in-practice of experienced nurses is acknowledged and enhanced. In such a programme, experienced nurses would have the opportunity

to engage in a dialogue about their own practice, bringing theoretical knowledge into the conversation of practice,¹¹ rather than the other way around.

Some of the approaches in this study could be used in such a programme. The study has provided the Sisters with several important opportunities to engage in conversations about their practice. In the course of the study the Sisters have had the opportunity to: describe their everyday experiences; to be listened and attended to; to have their practices witnessed; to see and comment on interpretations of their own and others' practice; to meet with others to share experiences in practice; and most particularly, to converse with others of the same level of experience and skill. They have been able to gain new perspectives on their practice: new links have been made and new dialogues opened with others and with their own practices. The conversation is about practising nursing and being attuned to experience. Through the conversation, naming ones own practices and seeing them legitimated can be a confidence-boosting, empowering experience.

It is not my intention to suggest specific ways in which the knowing-in-practice of experienced nurses can be valued and enhanced, but more productively perhaps, to suggest where the discussion on nursing practice and experience might go next. At the risk of oversimplification, it is my observation that when clinical nursing practice development is discussed in America, discussion often centres at the level of the specific nurse and her skills: responses to problems are individualized. Here in the United Kingdom, discussion often centres at the organizational level: what structures might be most useful to ensure standards, educational programmes or clinical advancement. This research demonstrates that to recognize and value knowing-in-practice while enhancing the process of being attuned to experience, a middle approach is needed: an approach which acknowledges the practising of individuals in an organization. Discussions would centre on ways of shaping the professional and organizational structures, including ongoing managerial and educational strategies, to enable individual nurses to develop excellence in everyday clinical practice. In order for these discussions to be successful, there must be adequate recognition of nurses' everyday experience in practice and its contribution to the development of nursing.

¹¹ I am indebted to Nancy Diekelmann and Steve Tilley who, from different beginnings, are also beginning to explore this notion of the conversation of nursing practice.

APPENDICES

APPENDIX 1

LETTER TO THE HEALTH BOARD REQUESTING ACCESS

Nursing Research Unit
Department of Nursing Studies
12 Buccleuch Place
Edinburgh EH8 9JT
May 26, 1987

Chief Area Nursing Officer
Health Board

Dear ,

The purpose of this letter is to request an appointment to discuss my proposed nursing research study, which I would like to carry out in the ____ Health Board.

I am currently a supervised postgraduate research student in the Nursing Studies Department, University of Edinburgh. My research is on the ways in which qualified nurses learn through their experiences in clinical nursing practice. Through this research, greater insight may be gained on how qualified nurses gain clinical, practical knowledge and develop clinical practice expertise. The study may also provide information on factors which help or hinder this development.

The planned study is descriptive, consisting of individual and group interviews, as well as participant observation. I would like to gain the participation of up to 15 experienced, registered general nurses who are considered by their peers to have clinical expertise and who work in direct clinical practice with patients in general surgical units in acute care hospitals.

As I am a Canadian nurse, I am unfamiliar with the particular circumstances of the hospital and health system which need to be considered in forming a responsive research plan. I would welcome the opportunity to meet with you or your delegate to explain my research plans and to receive advice on the next steps to take.

If you should need further information, please contact me at 667-1011 (ext. 6275) or my research supervisors, Professor P. Proffit (667-1011, ext. 6460) and Dr. Kath Melia (667-1011, ext. 6509).

I look forward to hearing from you.

Yours sincerely,

Martha L. MacLeod, R.N., B.A., M.A.
Supervised postgraduate student

c.c. Prof. P. Proffit
Dr. K. Melia

APPENDIX 2

LETTER TO THE DIRECTORS OF NURSING SERVICES

Nursing Research Unit
Department of Nursing Studies
Edinburgh University
12 Buccleuch Place
Edinburgh EH8 9JT
June 18, 1987

Director of Nursing Services
Hospital

Dear ,

I understand that Miss --- [Area Nursing Officer] has been in touch with you about my proposed research study on the processes whereby qualified nurses learn through their experiences in clinical practice. I would very much like to meet with you to discuss my research plans and to receive your guidance and advice in making the plans responsive and practical.

Briefly, the purpose of the research is to describe and explore the experiences of practising qualified nurses, through which they have learned to become clinically expert. Research subjects would be qualified nurses who are acknowledged to be experts in surgical nursing. In addition to having acknowledged expertise, these nurses would have been employed in nursing clinical practice for at least five years, and would be presently working in direct patient care in an inpatient surgical nursing unit. As I am attempting to do an in-depth study, the number of nurses is of lesser importance than gaining the participation of experienced, 'expert' nurses. My proposed research method is to involve the selected nurses in several individual and group interviews. As well, I would hope to be able to directly observe each participating nurse as she goes about her daily practice.

Through studying qualified nurses who have successfully learned through their clinical experiences, I am hoping to identify the features and value of such learning. This study stems from my experience in both surgical nursing and adult education. Prior to becoming a research student I was Director of Nursing Continuing Education at a large teaching hospital in Canada. I am hoping that the insights gained from this study will not only be of interest to practising nurses, but will also be of help to both nursing managers and educators in planning for nursing staff development and continuing education.

I would welcome the opportunity to meet with you to discuss these plans further. Should you require further written information about the study or myself, I would be pleased to provide it.

I can be contacted at the Nursing Research Unit (Tel.: 667-1011, ext. 6275). Should you wish to contact them, my research supervisors are Professor P. Proffit (667-1011, ext. 6460) and Dr. Kath Melia (667-1011, ext. 6509).

I look forward to hearing from you.

Yours sincerely,

Martha L. MacLeod RN, MA

APPENDIX 3

THE NURSES

Ward 1	Sister Jenny Aitkin
Ward 2	Sister Irene Baxter
Ward 3	Sister Hazel Calder
Ward 4	Sister Gail Dunn
Ward 5	Sister Fiona Ellis
Ward 6	Sister Ellen Fraser
Ward 7	Sister Donna Grant
Ward 8	Sister Cathy Hanna
Ward 9	Sister Beth Inglis
Ward 10	Sister Alison Jarvis

These names are pseudonyms. In the text the Nurses are usually referred to by their title and surname. I have maintained this style, as it is how they are referred to during their workday. On only a few occasions did I hear co-workers use their first names.

Since qualification the Nurses have had from 6 to about 33 years of nursing experience. Five have 6-12 years of experience in nursing and five have been in nursing for 24-33 years. Surgical nursing accounts for the majority of their nursing experience. Two have worked overseas, one in Australasia and one in the Middle East. Three of the long-term Nurses worked part-time when their children were young. One continues to work part-time. The Nurses have been in their present positions from 2.5 to 12 years, with a mean of 6.5 years in the post.

All qualified as registered general nurses (RGN or SRN); one initially trained as a Registered Orthopedic Nurse; and another qualified as a district nurse as part of

her basic nursing. This Nurse is a graduate, taking her initial nursing education in a university. One is taking a social sciences degree part-time. Two took initial nurse training in England; eight took it in Scotland. All are British-born women.

Following registration, several of the Nurses acquired additional qualifications: one became a Registered Sick Children's Nurse; two trained as midwives. Three took the year-long Intensive Care Course, one took the Ear, Nose and Throat Course, one has an Oncology Nursing course and one has an Enterostomal Therapy course. Two have taken a six-week Care of the Dying Course, one the Family Planning Course and three a health education short course. The eight sisters have taken at least one introduction to management course. All, save for one part-time staff nurse, have gone to a variety of study days. The continuing education opportunity for her has consisted of a fire lecture. By and large, the nurses in the study have continued their education by taking clinical courses and study opportunities which relate to their clinical work.

APPENDIX 4

LETTER TO THE SISTERS

Nursing Research Unit
Department of Nursing Studies
University of Edinburgh
12 Buccleuch Place
Edinburgh EH8 9JT
1987

Sr.
Ward
Hospital

Dear Sr. _____,

Thank you so much for agreeing to participate in the research study.

Briefly, the purpose of the research is to describe and explore the experiences through which practising qualified nurses have learned to become clinically expert.

Through studying qualified nurses, such as yourself, who have successfully learned through their clinical experiences, I am hoping to identify the value of such learning. I am hoping that the insights gained from this study will not only be of interest to practising nurses, but will also be of help to both nursing managers and educators in planning for nursing staff development and continuing education.

As we discussed, the study will consist of both observations and interviews. The findings of the study will be summarized and presented in a thesis for a Ph.D. degree in Nursing Studies at the University of Edinburgh. The findings may also be presented at conferences and/or published in professional journals. However, you will not in any way be identifiable. The interviews will be tape recorded, and then transcribed. Only I and my supervisors will have access to these tapes which will be kept under lock and key. You ultimately have control of the timing of the interview and the observations, and of course, may withdraw from the study at any time.

I hope that your questions so far have been answered, however, if you have any other questions or concerns, please do not hesitate to let me know. I can be contacted at the Nursing Research Unit (Tel: 667-1011 ext. 6770 or messages ext. 6268) or at home (Tel: 667-1639).

Sincerely,

Martha L. MacLeod, R.N.

APPENDIX 5

THE WARDS

The Sisters' wards have the following specialties: Gynaecology, Genito-urinary, General Surgery, Vascular Surgery, Orthopedic Trauma, Thoracic Surgery and Ear Nose and Throat Surgery. Wards are numbered in the order in which I undertook field work. The numbers do not coincide with the actual ward numbers.

Ward 1	20 beds	female	vascular surgery	Nightingale - style
Ward 2	21 beds	female	general surgery	Nightingale - style
Ward 3	22 beds	male	orthopaedic trauma	Nightingale - style
Ward 4	21 beds	male	thoracic surgery	8 bed critical care; 13 beds in 5 rooms
Ward 5	36 beds	mixed	ear, nose and throat	Eight 4-bed rooms and 4 single bed rooms along two corridors
Ward 6	36 beds	mixed	ear, nose and throat	Eight 4-bed rooms and 4 single bed rooms along two corridors
Ward 7	20 beds	male	vascular surgery	Nightingale - style
Ward 8	32 beds	female	gynaecology	Nightingale - style
Ward 9	21 beds	male	general surgery	Nightingale - style
Ward 10	32 beds	mixed	urology surgery	Six rooms for 2 to 12 patients along a narrow corridor

Although the Nightingale style wards had similar open ward and side room plans, they varied in the number of patients in the open ward and the number, capacity and placement of side rooms.

APPENDIX 6

INTERVIEW GUIDES AND PROBES

INTERVIEW 1

Tell me about:

A situation in which you feel your intervention really made a difference in patient outcome, either directly or indirectly (by helping other staff members)

A situation that went unusually well

A situation that is very ordinary and typical

A situation in which there was a breakdown (i.e., things did not go as planned)

A situation that you think captures the quintessence of what nursing is all about

A situation that was particularly demanding

What to include in the description:

The context of the situation(e.g., shift, time of day, staff resources)

A detailed description of what happened

Why the situation is 'significant'

What your concerns were at the time

What you were thinking about as it was taking place

What you were feeling during and after the situation

What, if anything, you found most demanding about the situation

(from Benner 1984)

INTERVIEW 2

What has happened since I last was here?

How has that influenced you?

Patients and other staff you have worked with who are memorable.

Can you think of patients you've cared for you'll never forget?

We all use examples to teach students

Relation of experiences now to earlier in your career...

Experiences in education programmes....

INTERVIEW 3

Tell me about the last two days:

I've seen you do

Do you remember when you didn't?

You seem to have a broader picture

People who have been influential

Outside experiences

What is most challenging now in your practice?

What is the meaning of learning through experience to you?

Reminder: Ask them to relate to earlier experiences

Demographics:

Position: former, chronology

Education

Professional qualifications

Patients: Numbers, average length of stay, acuity/dependency

Doctors: Length of time working with nurse/on ward

Staffing: Usual staffing, number of ward staff, grades, students: numbers, schools, years, teacher involvement

Nursing projects on the ward

Links with the community

Physical set-up: ward layout, equipment, environment - effects on nursing care

PROBES FOR EXPERIENCES IN THE INDIVIDUAL INTERVIEWS:

What else was going on at the time?

What were the other nurses doing?

What did it mean to you?/ Why was this important for you?

What were you thinking about while this was going on?/ afterwards?

What sort of things guided your action?

Has this influenced your practice since?

GROUP INTERVIEW

Your experiences in/ how you have dealt with:

Making it safe for patients and supportive for nurses where you are the only experienced nurse on the ward with very junior nurses.

Working in new or difficult situations in which you, yourself, have felt encouraged and supported.

Changes - Making things work through the changes.

Gaining and using your clinical authority in your ward - some of the milestones in the process.

APPENDIX 7

NOTATIONS USED IN QUOTATIONS IN THE TEXT

QUOTATIONS FROM FIELD NOTES

Field notes for each day were written onto the computer from notes taken hastily on the ward in a small notebook. As literary style was not an issue at the time, the style and verb tense of the field notes varied as to my recollection, state of energy or the content. For purposes of quotations in the text, I have made some minor stylistic changes:

- where pertinent, the tense has been changed to the present tense.
- sentence structure of some of my observations has been changed in a minor way; quotations taken at the time have not been altered.
- minor changes which add explanation, such as a patient's name or diagnosis, or number of days postoperatively, have been made. They are enclosed by square brackets.

In the field notes, the following have been used:

:: ::	Missed conversation. The greater the number, the more of a gap. Each :: means a phrase or short sentence
[...]	I have edited the field notes
...	Pause on the part of the speaker. The length of pause is indicated by the number of dots.
[word]	Explanatory notes
(word)	A response from other nurse present or the patient
<i>italics</i>	My interpretative comments which were written at the time in the field notes
Bold	My emphasis
CAPS	Speaker's emphasis

QUOTATIONS FROM INTERVIEWS

The interviews were transcribed verbatim, including all facilitative sounds such as "mm hmm", on the part of the interviewer. Where these facilitative sounds have not added to the quotation, they have been omitted and the speaker continues.

In the interviews, the following have been used:

- | | |
|-------------|--|
| [?] | Unintelligible - where a word is provided, it is the likely word |
| [...] | I have edited the interview |
| ... | Pause on the part of the speaker (number of dots indicate length - one per second) |
| Bold | My emphasis |
| CAPS | Speaker's emphasis |

Where the repetitions and hesitations do not add to the meaning of the quotation, they have been omitted. Only if they are lengthy, are they indicated by [...].

APPENDIX 8

SAMPLE INTERVIEW TRANSCRIPT

This original interview excerpt is from Interview 2-3: 3-8.

R. is the researcher, M. M.; N. is Sr. Baxter.

R: No no no that's fine. Um, ok because one of the things that I've noticed particularly about you, is how you are able to do your timing with women like her. Like another for instance in the last couple of days was with H. When the housing woman called and she said, "Can you talk to H. about this?" And you went up to H. and do you remember you're conversation with her?

N: Mm hmm. Mm hmm.

R: How. Could you describe it and I'll say then ah.. I'd like to know what you pick up from that? From your conversation.

N: From the conversation with H.

R: Yeah. How would you have described your conversation with H. then?

N: Um, is this the one once I had come off the phone.

R: Once you'd come off the phone.

N: And the lady was going to come and going to tell, the lady was coming to speak to her.

R: Mm hmm.

N: I would describe it as amenable and amicable, which I din't know if it would be.

R: Mm hmm.

N: Um because of the previous conversation we went through the day before. When she, when I mentioned housing and moving house she said "I'm not" added a few adjectives "going anywhere apart from home".

R: Mm hmm.

N: And so I thought, "Well if I mention it gently and quietly and bring in the good points about moving and how it would help her to move." Ho, are you wanting me?

- R: No I'm just wanting you to ...I'm wanting you to tell me how you.....the kind of things that you were just saying, that's how you went through that conversation.
- N: So I-I would choose to pick out the good points
- R: Un hunh
- N: And all the positives and the whys. Why it would be better. Try and see if she remembered the lady which, who she remembered when she actually saw her. So that she could mebbe put a face.
- R: Mm hmm.
- N: Or some contact with the lady she'd spoken to before. And not to get her ruffled. And not to start and say to her, "The lady's coming and you're going to sign the paper because you've got to move house."
- R: Mm hmm.
- N: I had to try to win her over to my side and then.....with the good points.
- R: Mm hmm.
- N: And the better points of why it would be good to do that.
- R: Mm hmm. Cause what I saw in addition to that was the timing. Of how.... You didn't broach that subject right away.
- N: Mm hmm.
- R: You found out how she was. You listened to her tell you a bit about how she was feeling and what she was and then you, you said um,...I forget exactly what you said. It was something about the the moving house.
- N: Mm hmm.
- R: And just the way, it was it was um, you didn't rush in to do it. You just took your time to do it. Were you aware of that at the time?
- N: Un hun. Probably. I would get some responses from the way H. looks.
- R: Mm hmm.
- N: And if she's um.. Oh you can tell. She smiles sometimes. Sometimes she looks a bit, not strange, a bit more um positive when she's she's determined not to do something. Or you can tell the look of determination. That means she's got what she wants to do on her mind. And when you see that coming, or when I see it coming or I see that look of em questioning on her face then I know that that's enough.
- R: Mm hmm.

- N: I know that I I don't go any further. It's like this morning when she wouldn't take her medicines.
- R: Mm hmm.
- N: Ah let's say an example. She was taking tiny wee sips. And if I had forced it she wouldn't have touched it at all. I think now, that's the feeling I got.
- R: Yeah.
- N: That if if I pushed through then she would just say, "Well I'm not.." She would begin to use her adjectives again. "I'm not going to take it." And I think that was, I think she wouldn't have touched it. So it's better to let her do it in her own time.
- R: Mm hmm. And I saw again you did that with um G. this morning. Where "I won't stand over you while you take that medicine."
- N: Mm hmm.
- R: And you left her to see if she could do it on her own. Do you remember a time when you didn't have that ability? That you didn't do it that way?
- N: Mm hmm. Probably. I remember I use to work up in the neuro surgical unit. And I hadn't long been there and and insisting that patients must take their medicine. You, you sign for them and and to a certain extent it's true. I mean you're signing to say that they've taken them and if the patient hasn't taken them you've signed it. So that that in effect is wrong.
- R: Mm hmm.
- N: It's not that's the [legal? in a ? minded way. And um there used to be patients who, it was quite a cr. They became quite restless because of their illness and I don't think, you couldn't reason with them. Somehow these patients had to get their medicines.
- R: Mm hmm.
- N: And I felt that I had this right. That I have for the patient to take it whether they wanted it or not.
- R: Mm hmm.
- N: With experience. Just with with dealing with people like H. and G. that are quite determined in their own way. In the end I found out that you know, you don't go in.. You, you get more by going at their pace.
- R: Mm hmm. Can you remember....that turning point for you?
- N:I can't. I can't say that it um is something that's quite foremost in my mind.

R: No, but you remember that.

N: But I do I do remember.

R: The change happening.

N: Mm hmm mm hmm. And that was, that was when I was a staff nurse but I had been qualified for mebbe a year or so before that.

R: Mm hmm.

N: But that turning point came in dealing with people who, were agitated who weren't. You couldn't communicate with as easily as, I suppose as with H. And that I that somehow over that period I came to the, not conclusion, but I understood that people were people.

R: Mm hmm.

N: And that you had to go with them as people. And that you've got twenty people on the ward and they're all different.

R: Mm hmm.

N: And whilst you can't have routines for everyone of them to their own individual needs you've got to try, and to a certain extent go with them.

R: Mm hmm. Cause that's something I see you do very easily and very well. Um and that's one thing I wondered, how you came to know that.

N: [Can't really tell]? Ah I'm aware. I'm aware of it happening.

R: Mm hmm.

N: I don't know when. But I'm aware of now .

R: Being different.

N: Being different from from how I used to be in that respect. And that and I think that was when I, I realized that they were people. And it didn't matter because you've signed a piece of paper, as long as they took it. You know. And it wasn't something detrimental to their health or it wasn't they had to have now and then even if they didn't want it, you would have to do it. I mean, you know. And that you did have a wee way of ?

R: Mm hmm.

N: And there were some situations you approached ...differently from others. And I-I don't know. That's something that I .. sensed.

R: Mm hmm.

- N: You know sometimes that if there is somebody who won't do anything, you've got to be firm. And mebbe had G. F. been here for longer and she wasn't going to take it. And she wasn't going to take her medicine, then that for the long term couldn't persist. And you'd have to think of some plan to help her.
- R: Mm hmm.
- N: And it may be that you would have to be a wee bit moreum ...forthright in some things, in some respects.
- R: Mm hmm.
- N: And give them leeway in others.
- R: Yeah.
- N: Because over a long period of time mebbe that wouldn't be the approach every time. If she wasn't going to cooperate in any way.
- R: Mm hmm.
- N: That you've mebbe got to win their confidence probably, before. They're like children in many ways. You've got to gain their confidence before they'll do something for you.
- R: Mm hmm.
- N: And you're not going to get that if you begin being, "Do this and do that and don't, do what I say.
- R: Mm hmm.
- N: You don't get it if you start out in that way.

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